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**Psychological Impact of Female Genital Mutilation and Mechanisms
of Maintenance and Resistance in Harmful Traditional Practices
against Women and Girls**

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This thesis is submitted in partial fulfilment of the requirements for
the degree of Doctorate in Clinical Psychology

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Declaration

This thesis has not been submitted for any other degree or to any other institution. Emergent findings from the empirical paper were submitted as a poster presentation at the Division of Clinical Psychology West Midlands Continued Professional Development Day. This thesis was carried out under the academic and clinical supervision of Dr Helen Liebling (Senior Lecturer-Practitioner in Clinical Psychology, Coventry University), Dr Simon Goodman (Research Fellow, Coventry University), and Professor Hazel Barrett (Associate Dean for Applied Research), all of whom were involved in the initial formulation of research ideas and in the development of the research design. Apart from the collaborations stated, all the material presented in this thesis is my own work. The literature review and the empirical paper is written for submission to the *Journal of International Women's Studies*, and the reflective paper is written for submission to the *British Psychological Society: Psychology of Women Section Review*.

List of Abbreviations

| | |
|---------------|--|
| FGM | Female Genital Mutilation |
| FGM/C | Female Genital Mutilation / Circumcision |
| HIV | Human Immunodeficiency Virus |
| HTP | Harmful Traditional Practice |
| NGO | Non-government Organisation |
| NHS | National Health Service |
| PTSD | Post-Traumatic Stress Disorder |
| STD | Sexually Transmitted Disease |
| UK | United Kingdom |
| UN | United Nations |
| UNICEF | United Nations International Children's Emergency Fund |
| WHO | World Health Organisation |

Glossary

| | |
|--|--|
| Child marriage | The formal marriage or informal union of children under the age of 18. |
| Dowry | Money, or goods that a woman brings to her husband in exchange for marriage. |
| Dyspareunia | Painful intercourse. |
| Female Genital Mutilation (FGM) | All procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. |
| FGM Type 1 | Partial or total removal of the clitoris or, in very rare cases, only the prepuce |
| FGM Type 2 | Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. |
| FGM Type 3 | Narrowing of the vaginal opening through the creation of a covering seal. |
| FGM Type 4 | All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising. |
| Harmful traditional practice | Behaviour or actions carried out in the name of tradition which cause physical or emotional harm to those affected. |
| Keloids | Excessive growth of scar tissue. |
| Micturition difficulties | Difficulties with urinating |
| Obstetric | Period of time before and after childbirth. |
| Obstetric fistulae | A hole between the vagina and rectum or bladder that is caused by prolonged obstructed labour, leaving a woman incontinent of urine or faeces or both. |
| Perinatal risks | Risks immediately before and after birth. |
| Practising community | Communities that engage in harmful traditional practices. |
| Son preference | Preference towards the male child. |

Summary

Gender-based harmful traditional practices (HTP) are prevalent in many countries across the world and have a severely negative impact on the physical and psychological health of women and girls. This thesis informs understanding of the factors that both perpetuate and inhibit resistance to HTPs. It further provides understanding of the psychological impact of female genital mutilation (FGM) informing both clinical and policy action.

Chapter one is a critical review of both quantitative and qualitative literature exploring factors that perpetuate and facilitate resistance to HTPs. Following both database and manual searches, 21 studies were included and reviewed. Women who had experienced or carried out harmful traditional practices of son preference, FGM or child marriage, relate educational status, residential location, economic status, and family history of practising FGM as sociological facets that perpetuate HTPs. Negative health implications and female autonomy are considered factors that facilitated resistance to HTPs, and religion, tradition and patriarchy serve as control mechanisms that inhibit resistance to HTPs.

Chapter two is a qualitative research study that explores women survivors' experiences of FGM and the resultant psychological impact. The development of a theoretical model shows women related lack of knowledge, female identity, religion, culture, role of men, and deception as reasons for the practice of FGM. Experiencing FGM impacted on the physical, identity, emotional, and relational aspects of women's lives. All of these factors, in addition to women's resilience, were influenced by key stages of their life including menstruation, sexual intimacy, and having a child, as well as by fear and unmet needs due to insufficient service provision.

Chapter three is a reflective account, exploring the challenges encountered throughout the research process, as well as reflecting on issues of counter-transference between the researcher and the participants, their impact, and their management.

Overall word count: 19,997

Chapter 1: Literature Review

**Title: Persistence and resistance of intergenerational harmful
traditional practices against girls in Africa and Asia**

Overall chapter word count (excluding tables, figures, and references): 7,816

Written in preparation for submission to Journal of International Women Studies

(See Appendix A for author guidelines and email from editor)

1.0. Abstract

Background: Harmful traditional practices (HTP) are deeply entrenched behaviours or actions. They violate the human rights of affected individuals due to the negative consequences the practices have on the physical and psychological health, social rights and political equality of affected individuals and communities. Despite legislation making HTPs illegal, many practices continue today, causing considerable health risks to women and girls. Whilst it is evident that there are HTPs that have successfully been eradicated, the mechanisms underpinning the continuation of currently practiced HTPs remain unclear. Whilst studies have sought to understand factors perpetuating different HTPs, there is a paucity in reviews that synthesise these findings. **Aims:** The aim of the current review was to consider son preference, female genital mutilation, and child marriage in relation to their persistence in line with their potential for eradication. **Method:** A systematic literature review of 21 studies. **Results:** Women of practising communities identified educational status of women, residential location, economic status, and a family history of practising HTPs as sociological factors perpetuating HTPs. Negative physical health consequences and women's autonomy were identified as facilitating resistance to HTPs, while religion and patriarchy were identified as mechanisms that prevented resistance to HTPs. Clinical, policy and future research implications are considered.

Keywords: *Son preference, female genital mutilation, child marriage, review*

1.1. Introduction

1.1.1. What are harmful traditional practices?

Iyanuolu (2008) argues, ‘traditional’ or ‘cultural’ practices refer to long established patterns of actions or behaviours that are reproduced throughout generations. These customs become deeply entrenched social norms that provide groups of individuals with a framework of relational and behavioural values that permit both individual and group identity to a specific social heritage.

Consistent with the Universal Declaration of Human Rights and the Convention of the Rights of Child (UN General Assembly, 1948; 1989 respectively) traditional or cultural practices considered ‘harmful’ are those that hold negative consequences for the physical or psychological health of affected individuals, as well as having adverse social and political implications (Hanzi, 2006; Iyanuolu, 2008).

Whilst HTPs are carried out against both males and females, most are against women and girls thereby making HTP a particularly gendered issue.

1.1.2. Harmful traditional practices against women and girls

Son preference, child marriage and female genital mutilation (FGM) are considered the most prevalent HTPs (Stop Violence Against Women, 2010). These practices severely violate women’s rights to non-discrimination, health, and bodily integrity. The threat they pose to the lives of girls and women means these practices also infringe rights to life, liberty and security of person. Due to their high prevalence, these three HTPs form the focus of this review.

1.1.3. Son preference

Worldwide, some of the most harmful traditional practices against women and girls stem from a preference towards the male child. While instances of daughter preference, such as in Romani gypsy communities, do exist, this review focusses on son preference. Son preference refers to a collation of values and attitudes that manifest into divergent practices of which the collective feature is a preference for a son, concomitant often with daughter neglect. Son preference is most pertinent in Southern and Central Asian countries, Northern Africa, and Eastern European countries (Arnold, 1992; 1997). Consequences of son preference include skewed sex ratios and excessive risk of neglect and mortality in young girls (Pande & Malhotra, 2006).

Partiality for a male child can lead to a reduction in the quality of prenatal care for girls, differential vaccination rates (Oster, 2009), unequal allocation of intra-household resources (Pitt & Rosenzweig, 1990), differential breastfeeding behaviour (Jayachandran & Kuziemko, 2011) and differences in parental time allocation (Barcellos, Carvalho, & Lleras-Muney, 2010). In extreme circumstances, son preference can lead to sex-selected abortion and female infanticide (Chen, Yuyu, Hongbin Li, & Meng, 2013).

1.1.4. Female Genital Mutilation

FGM includes all procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons (WHO, 2014). Whilst precise prevalence statistics are unknown due to the covert nature of its practice, it is estimated that worldwide more than 200 million girls and women have been ‘cut’. It is predominantly practiced across 30 countries in Africa, the Middle East and Asia (UNICEF, 2016; Ghadially, 1991; 1992; Dahlui, 2012; Rashid, Patil, & Valimalar, 2010; Al-Hinai, 2014; Alsibiani, & Rouzi, 2010; Al-Marzouqi, 2011) with evidence that it also exists in areas of South America (UNFPA, 2011), and in some parts of Europe and Australia (UNICEF, 2013).

The practice is predominantly carried out on young girls between infancy and 15 years by older women within a society and it carries with it a number of severe physical and psychological health complications. Short-term complications can include pain, excessive bleeding, shock, genital tissue swelling, infection, spread of human immunodeficiency virus (HIV), micturition problems, and death (WHO, 2008). Long-term complications can include pain, infections, menstrual difficulties, keloids, obstetric complications, obstetric fistulae and perinatal risks. Survivors of FGM are also at risk of developing post-traumatic stress disorder (PTSD) (Kizilhan, 2010).

1.1.5. Child marriage

Child marriage is defined as the formal marriage or informal union of children under the age of 18 years (UNICEF, 2014). Whilst in many countries the legal age for marriage is 16 years, marriage under the age of 18 would require parental consent. As the majority of children entered into child marriage are coerced or forced due to social or familial pressure (UNICEF, 2012), for the purpose of clarity, the definition of child marriage within this review should be considered in parallel to Article One of the Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages (United Nations, 1964, p.1) which asserts that:

No marriage shall be legally entered into without the full and free consent of both parties, such consent to be expressed by them in person.

Whilst boys are at risk of being victim to child marriage, it disproportionately impacts on girls (Girls not Brides, 2016). It is estimated that more than 700 million women alive today were married before the age of 18, with one in three being married before the age of 15

(UNICEF, 2014). Child marriage is most dominant in South Asian and sub-Saharan African countries.

According to UN Women (2013), child brides are frequently disempowered and deprived of their right to health, education, and safety. With the expectation that young brides become pregnant instantaneously, there is increased risk of complications during pregnancy and childbirth due to physical immaturity. Globally, it is estimated that pregnancy and childbirth is the second leading cause of death amongst adolescent girls. Despite being illegal in many countries, legislation to protect young girls is not well enforced, resulting in a violation of their human rights.

1.1.6. Rationale and aims of literature review

Despite legislation making son preference, FGM, and child marriage illegal, these practices still continue today, leading to considerable health consequences for women and girls.

Though there are HTPs such as Chinese foot binding, that have successfully been eradicated, it is unclear what mechanisms facilitated their abolition and what the influences are which allow HTPs to continue.

Whilst there is a considerable body of research that has sought to understand the factors that perpetuate different HTPs, there is a lack of available evidence that synthesises the review findings. A recent systematic review by Berg and Denison (2013) identified six key factors that underpin the perpetuation of FGM inclusive of cultural tradition, sexual morals, marriageability, religion, health benefits, and male sexual enjoyment. They further identified four factors that hindered the continuation of FGM: health consequences, lack

of religious requirement, illegality, and host society rejection of FGM. Although this review provided helpful insights into the continuation of FGM, it did not consider wider HTPs: consequently, links could not be made between the continuation of FGM and other forms of HTP against women and girls. Furthermore, their review focused on studies where participants resided in Europe, thereby limiting the degree to which findings could be generalised to practices in Africa and Asia where the majority of HTPs are carried out.

In view of the paucity of published data, the current systematic literature review critically evaluated literature relating to the underlying reasons for the persistence and resistance to son preference, FGM, and child marriage, and addressed the following questions:

1. What are the sociological factors that perpetuate HTPs?
2. What factors facilitate resistance to the continuation of HTPs?
3. What are the control mechanisms that inhibit resistance to HTPs?

1.2. Method

1.2.1. Search strategy

Having established from a search of the Cochrane Database of Systematic Reviews, and The Centre for Reviews and Dissemination (DARE) that the proposed review was an original concept, a systematic literature search for studies that had investigated the persistence and resistance of son preference, FGM, and child marriage in Africa and Asia was undertaken between August 2015 and March 2016. Pictorial representation of the study selection procedure in accordance with the PRISMA guidelines (Moher et al., 2009) is depicted in Figure 1.1 on page 11.

1.2.2. Electronic database search

A search of the most relevant databases, which covered literature within psychological, sociological and medical disciplines was carried out. Databases included Scopus, Web of Science, PsychINFO, Medline Ovid, and Applied Social Science Index and Abstracts. As depicted in Table 1.1, article search terms were based on their relevance to the research questions and included the main concepts of child marriage, son preference and FGM. Synonyms of these terms were also identified to facilitate the generation of all research relevant to the review.

Table 1.1: Table Illustrating Search Terms Utilised in Review

| | Search terms | Synonyms | Location of search term |
|--|---------------------------|--|---------------------------------------|
| Initial search terms | Child marriage | Early marriage OR young marriage OR childhood marriage | Title AND / OR Abstract |
| | Son preference | Sex selective abortions OR female infanticide | |
| | Female genital mutilation | Female genital cutting OR female genital circumcision, OR FGM/C OR FGC | |
| Secondary search term (Combined with, OR, then AND) | Persistence | Perpetuate OR continuation, OR resistance OR origins OR reason OR rationale OR causes, OR risks | Title AND / OR Abstract |

1.2.3. Manual search

Following the electronic database search, a manual search for additional relevant references was carried out using the reference lists of previously extracted studies. An online search of relevant literature and websites was also performed using Google Scholar, Amnesty International, and European Institute for Gender Equality (EIGE). Non-electronic searches were also executed using the library book catalogues. To ensure a

complete search of all available literature pertaining to the aims of the literature review, an online search for grey literature was also conducted using psycEXTRA and The Healthcare Management Information Consortium (HMIC). Grey literature has been found to contribute 10% of referenced sources in Cochrane reviews (Mallett, 2002).

1.2.4. Inclusion and exclusion criteria

Article titles and abstracts were initially screened and retained if they: (a) were written in English, (b) were peer reviewed, (c) described a qualitative, quantitative or mixed methods study, (d) addressed causes or reasons pertaining to the perpetuation of HTPs, (e) the full text was accessible, and (f) published between 2006-2016. Date parameters were elected to ensure the most up to date research was reviewed.

Following initial screening, full-text articles were obtained and assessed for eligibility for the review according to the following set of specific inclusion criteria:

Specific inclusion criteria: Studies were included if participants were: a) female, and b) self-identified as having undergone or practised one or more of the three specific HTPs: son preference, child marriage, or FGM. Focus on women participants only was elected as all three practices are carried out by women and it was therefore important to consider their role and relationship with the practice.

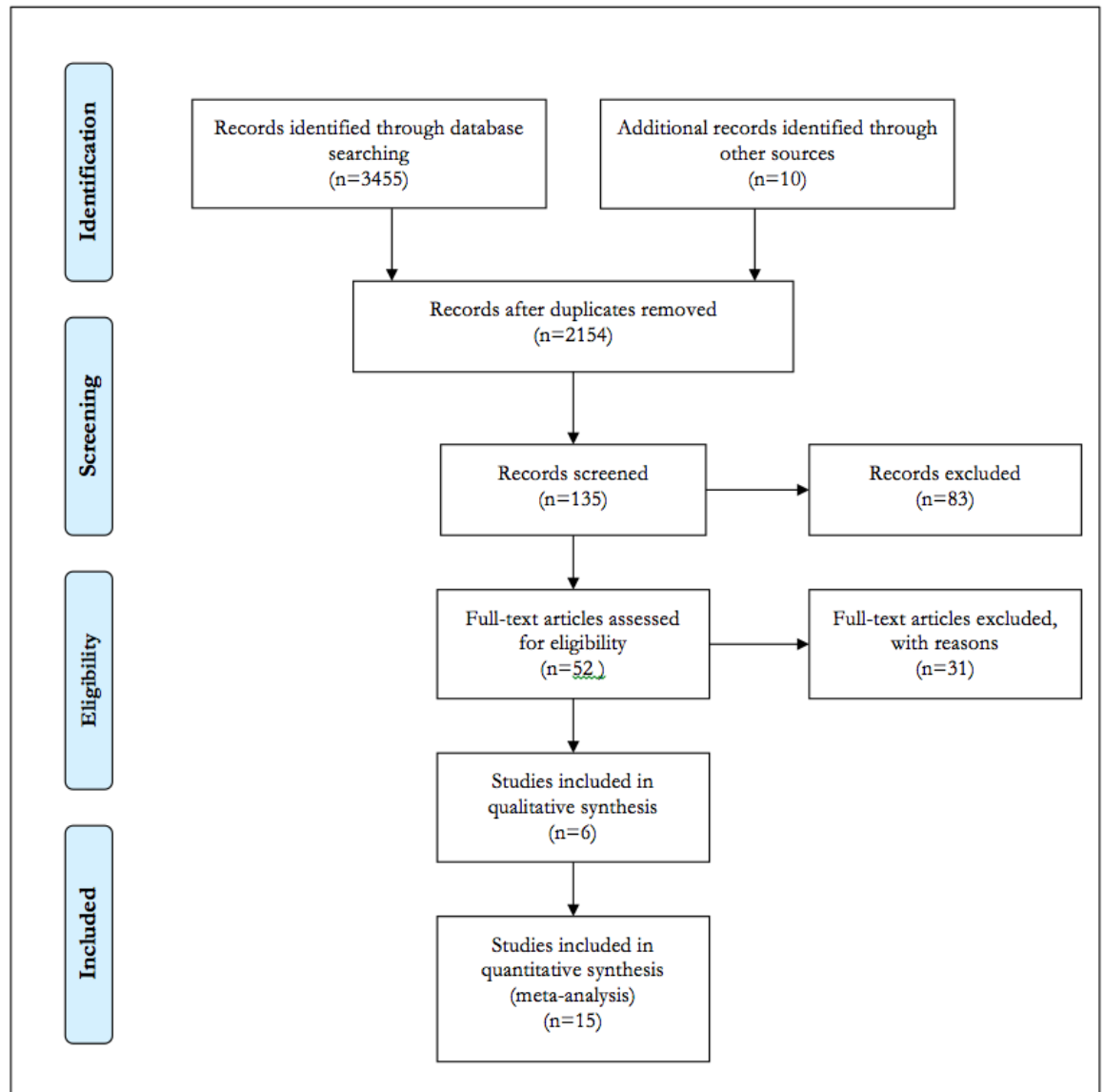
No limits were placed on the study design, sample size, recruitment method used or method of data collection. Studies were included for review if they assessed the causes of at least one HTP of child marriage, FGM, or son preference.

Specific exclusion criteria: Studies were excluded if they used a sample population a) outside of Africa or Asia, and b) if they were males or health care professionals.

1.2.5. Classification of studies

The process of study selection was recorded on a 'Preferred Reporting Items for Systematic Reviews and Meta-analyses' (PRISMA) flow diagram (see Figure 1.1). A total of 3,465 articles were initially identified from both electronic databases and manual searches. Of these, 2,154 were duplicates, resulting in 135 satisfying the inclusion and exclusion criteria. Following a manual review of the title and abstracts, a further 83 records were excluded as not relevant. The full text for the remaining 52 articles was reviewed and a further 31 were excluded as non-primary research such as case studies or commentaries. Twenty-one relevant studies that satisfied the inclusion criteria formed the basis for the review.

Figure 1.1: Systematic Search strategy in accordance with PRISMA



1.2.6. Quality assessment framework

Studies selected for inclusion in the review were assessed for quality using Caldwell, Henshaw and Taylor's (2005) Critical Appraisal Framework (CAF) [Appendix B]. While it was recognised that there were a number of quality assessment tools available, following Caldwell, Henshaw and Taylor's (2011) acknowledgement of historical limitations in measuring qualitative studies against quantitative criteria, the CAF was chosen due to its applicability to both qualitative and quantitative research.

1.2.7. Results of quality appraisal

The CAF consists of 18 questions relating to differing areas of quality. Study quality scores were based on a three-point Likert scale indicating the degree to which the criteria had been met (0=criteria not met, 1=criteria partially met, 2=criteria fully met). The rating for each article was calculated by adding the scores for all 18 criteria, giving a maximum score of 36 points. For each article, a total percentage score was calculated to allow for fair comparison across studies. Articles that scored below the midpoint of 18 (50%) were excluded as they were not considered to reach a satisfactory level of rigour. Appendix C depicts the CAF scores for each paper. Results showed all studies attained a quality score above the 50% threshold (range=63-94%; mean=81.47%) and were retained. To enhance reliability, another researcher rated three articles independently against the CAF criteria and an inter-rater reliability analysis using the Kappa statistic was performed. Results (Kappa=0.80) suggested strong inter-rater reliability [Appendix D]. Final quality percentages are illustrated in Table 1.2.

1.2.8. Characteristics of studies

Key characteristics of the 21 studies included in this review are detailed in Table 1.2. Of the 21 studies, 10 used sample populations from Asia, (India=4, South Korea=1, China=1, Iran=2, Iraq=1, Pakistan=1) and 11 studies used sample populations from Africa (Burkina Faso=1, Eritrea=1, Egypt=3, Nigeria=2, Ethiopia=2, Bangladesh=2).

Six of the studies used a qualitative design that included focus groups and/or semi-structured interviews; 15 studies used a quantitative design (fixed-response measures/structured interviews). Of those that used quantitative methods, six studies used pre-existing data such as household census reports.

Purposefully, all samples were women who had undergone or practised one or more of the three specific HTPs; 5 studies focussed on son preference, 11 studies focussed on FGM, and 5 studies focussed on child marriage.

Samples sizes varied across the studies, with quantitative studies samples ranging from 385 to 17,579 participants (mean=4,249), and qualitative studies having samples that ranged from 11–634 (mean=193).

All 21 studies assessed differing variables considered to perpetuate the continuation of HTPs.

Table 1.2. Characteristics of reviewed articles

| Authors, date, title of paper | Sample information and location of recruitment | Aims and areas covered | Design and data collection information | Key findings relating to origins / perpetuate or resistance to HTP | Quality rating score |
|---|--|--|--|--|----------------------|
| Son Preference | | | | | |
| Chavada, M. and Bhagyalaxmi, A. (2009) Effect of socio-cultural factors on the preference for the sex of children by women in Ahmedabad district | N = 385 ($n=192$ from urban areas, $n=193$ from rural areas) Mean age 30.79 years (range 15-49 years) All married women of Hindu religion Random sampling strategy Ahmedabad District, Gujarat, India | <i>Aims:</i> to understand the effects of socio-cultural factors on preference of the sex of children <i>Areas covered:</i> female level of education, rural versus urban areas, family patterns, cultural factors | Quantitative method Cross sectional study using quantitative interviews Analysed using chi square analysis | Significant association between low education and son preference; ($X^2=14.11, p>0.01$) Significant association between son preference (87.53%) and low social classes ($X^2=2.10, p>0.05$). Significant association between rural residence and son preference ($X^2=15.02, p<0.0001$). | 83 |
| Diamond-Smith, N., Luke, N., and McGarvey, S. (2008) Too many girls, too much dowry: son preference and daughter aversion in rural Tamil Nadu, India | $n=58$ females from nine villages in two districts of Tamil Nadu. All respondents were of childbearing age. Random sampling strategy Tamil Nadu, India | <i>Aims:</i> to identify themes regarding fertility preference among rural Tamil Nadu <i>Areas covered:</i> fertility, family planning, sterilization, overall health, economics, family structure. Perceptions of both boy and girl preferences. | Qualitative method Semi-structured interviews Analysed using N-vivo 2.0 | Key themes affecting son preference: fertility history, knowledge of abortion, knowledge of STDs, breastfeeding, economic decision making, perceived benefits of boy / girl children, dowry and daughter aversion, | 94 |

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| <p>Chung, W. (2007).</p> <p>The relation of son preference and religion to induced abortion: The case of South Korea</p> | <p>n=6348 married women aged between 15-49 years.</p> <p>South Korea</p> | <p><i>Aims:</i> factors that influence the practice of induced abortion with a focus on son preference.</p> <p><i>Areas covered:</i> influence of religion, composition of previous children.</p> | <p>Quantitative method</p> <p>2000 Korea National Fertility and Family Health Survey</p> <p>Structured interviews</p> <p>Superfluous abortion ratio index</p> <p>Analysed using multivariate regression</p> | <p>Likelihood of induced abortions in women with two or more children, compared with those with one child, was significantly influenced by the sex composition of the previous children: OR=12.71 (95% CI=5.49, 29.42) for women with only son(s), and OR=.91 (95% CI=1.67, 9.14) for women with only daughter(s).</p> <p>At parity two, women with two sons were much more likely to have induced abortions than women with two daughters (OR=5.88, 95% CI=2.70, 12.85).</p> | 86 |
| <p>Lei, L. and Pals, H. (2011)</p> <p>Son preference in China: Why is it stronger in Rural areas?</p> | <p>n=3208</p> <p>Stratified sampling method from four strata: county, town, community, household.</p> <p>China</p> | <p><i>Aims:</i> to ascertain reasons for higher rates of son preference in rural areas</p> <p><i>Areas covered:</i> residential location, education, perception of son's cultural utility, gender role beliefs, patriarchal beliefs</p> | <p>Quantitative method</p> <p>Chinese General Survey</p> <p>Structured questionnaires</p> <p>Analysed using binary logistic regression and linear regression models</p> | <p>77% higher odds of son preference in rural areas comparative to urban areas ($p<0.001$)</p> <p>Higher education reduces the odds of son preference (OR=0.93; $p<0.001$)</p> <p>Perception of sons as culturally useful increases odds of son preference (OR= 3.14; $p<0.001$)</p> <p>Belief that sons are necessary for family lineage increases odds of son preference (OR=2.89; $p<0.001$)</p> | 80 |

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| <p>Kapadia, R., Parikh, S, Patel, M., and Bharucha, P. (2015)</p> <p>Factors influencing son preference and daughter non-preference among married women in urban and rural areas of Ahmedabad District: A cross-sectional Study</p> | <p>n = 415 females</p> <p>Random sampling method</p> | <p><i>Aims:</i> to find socio-demographic factors associated with sex preference and reasons for the preferences.</p> <p><i>Areas covered:</i> residence, socio economic class, religion, caste, education</p> | <p>Quantitative method</p> <p>Pro-forma structured interview method</p> <p>Analysed using chi square analysis</p> | <p>Key findings:</p> <p>Women living in urban areas were more likely to have a son preference ($X^2=4.47$, $p<0.05$).</p> <p>There was no significant difference between social economic status and son preference ($X^2=1.88$, $p>0.05$).</p> <p>Reasons given for son preference included:-</p> <p>Old age security (urban areas 66.13%, rural areas, 91.57%, $Z=6.28$).</p> <p>Income purpose (urban areas 67.74% - rural areas 89.33 %, $Z=5.35$).</p> <p>Social status (urban areas 11.29% rural areas 5.61%, $Z = 1.96$).</p> <p>Common reasons for non-preference of daughters were dowry problems (urban areas 14.52%, rural areas, 85.95%.</p> | 63 |
| Female Genital Mutilation | | | | | |
| <p>Karmaker, B., Kandala, N-B., Chung, C. and Clarke, A. (2011)</p> <p>Factors associated with female genital mutilation in Burkina</p> | <p>n=12,049 females aged 15–49 years</p> <p>77% had undergone FGM, 30.2% had not undergone FGM</p> | <p><i>Aims:</i> to understand risk factors leading to likelihood of FGM having FGM and likelihood of practising FGM on daughter</p> <p><i>Areas covered:</i> age, religion, wealth, ethnicity, literacy,</p> | <p>Quantitative method</p> <p>Demographic Health Survey (DHS)</p> | <p>For both outcomes (i.e. women or daughter FGM status), age, religion, place of residence, household socio- economic status (health or wealth Index), maternal education, place of residence, province of residence, and ethnicity were all</p> | 86 |

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| Faso and its policy implications | Stratified random sampling Africa | education, household affluence, region, responsibility of household decisions, | Structured interviews Analysed using logistic regression modelling | significantly related to the two outcomes ($p<0.01$). | |
| Mohammed, G.F., Hassan, M.M., and Eyada, M.M. (2015) Female genital mutilation / cutting: Will it continue? | n=2106 women aged 18– 60 years (mean=29.1) 90.7% of participants had FGM / C Computerised random sampling Egypt | <i>Aims:</i> motives behind the continuation of FGM/C in Egyptian the community and evaluation of sexual function in women with FGM/C <i>Areas covered:</i> age, religion, residency, education level, sexual orientation, motives for FGM, if practice should continue, satisfaction with sexual life, male attitudes towards FGM | Quantitative method Female Sexual Function Questionnaire Structured personal interviewing Closed ended questionnaire Physical examination | Socio-demographic factors inclusive of education, residency, religion, age were predictors of likelihood to have had FGM ($p<0.05$) | 83 |
| Ashimi, A. O. and Amole, T. G. (2015) Perception and attitude of pregnant women in a rural community north-west Nigeria to female genital mutilation | n=323 pregnant women attending antenatal care Aged 15-40 years (mean=23.7). 95.4% were Muslim, 4.6% were Christians. Systematic random sampling Jigawa state, Nigeria | <i>Aims:</i> to gain insight into pregnant women's perception and attitudes towards FGM <i>Areas covered:</i> understanding of types of FGM, reasons for performing FGM, and willingness to support and perform FGM | Quantitative method Structured Questionnaire Analysed using Chi-square or Fishers tests for comparison of proportions. | Most influential factors for carrying out FGM included tradition (34%), ease difficult childbirth (26.9%), marriage prospects (21.5%), prevent promiscuity (12.5%), sexual pleasure (7.0%), social acceptance (4.3%), religion (2.7%), cleanliness (1.2%), to protect virginity (0.8%). Demographic factors predicted chances of having FGM: age ($X^2=1.14$, $p<0.29$), employment status ($X^2=6.280.45$, $p<0.50$), | 80 |

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| | | | | education ($X^2=6.07$, $p=0.014$) and religion ($X^2=6.28$, $p=0.68$) | |
| Abdelshahid, A. and Campbell, C. (2015) Should I circumcise my daughter?' Exploring diversity and ambivalence in Egyptian parents' social representations of female circumcision | n=11 mothers aged between 22-60 years Egypt | <i>Aims:</i> to identify the psychosocial factors that shape parents' decisions to circumcise or not circumcise their daughters. <i>Areas covered:</i> sexuality, religion, mothers experience, cultural identity | Qualitative method In depth open ended interviews Thematic analysis | Key themes: daughters sexual control, sexuality of women, rite of passage, norms and traditions, community and marriage, preserving community identity, sexual response dilemma, parental distress on FGM day. | 86 |
| Bogale, D., Markos, D., and Kaso, M (2014) Prevalence of female genital mutilation and its effect on women's health in Bale zone, Ethiopia: a cross-sectional study | n=634 women (mean age 30 years) Stratified random sampling method used for quantitative phase of study Purposive sampling strategy used for qualitative phase of study Ethiopia | <i>Aims:</i> to ascertain prevalence of FGM, health consequences, factors underpinning practice of FGM <i>Areas covered:</i> residency, religion | Qualitative method Focus group discussions In depth interviews Analysed using thematic analysis then coded quantitatively and analysed using logistic regression | Key themes: FGM carried out to aid marriage, social acceptance, safeguarding of virginity. | 80 |
| Dehghankhalili, M., Fallahi, S., Mahmudi, F., Ghaffarpasand, F., Shahrzad, M. E., Taghavi, M., and Fereydooni-Asl, M. (2015) Epidemiology, regional characteristics, | n=780 women aged 14-38 years (mean = 30.5) Data gathered over a 36-month period from 2010 to 2013 in Hormozgan, a southern province | <i>Aims:</i> to describe the epidemiology, regional characteristics, knowledge, and attitude toward FGM/C in Southern Iran. <i>Areas covered:</i> demographic characteristics, tradition, religion, family history of | Quantitative method Structured interviews carried out by a trained medical student | FGM/C was associated with higher age ($p=0.002$), Afghan nationality ($p=0.003$), Sunni Islam as religion ($p=0.019$), illiteracy ($X^2=p<0.001$), and family history of FGM/C in mother ($p<0.001$), sister ($p<0.001$), and grandmother ($p<0.001$). Ancient traditions in the area (57.1%) were | 77 |

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| knowledge, and attitude toward female genital mutilation/cutting in Southern Iran | of Iran near the Persian Gulf. Iran | FGM | Physical examination Chi square and t-test analysis | mentioned as the most important factor leading to FMG/C. | |
| Besera, G. and Roess , A. (2014) The relationship between female genital cutting and women's autonomy in Eritrea | n=8754 aged between 15-49 years Africa | <i>Aims:</i> to investigate the relationship between women's autonomy and attitudes toward FGM and having a daughter with FGM in Eritrea <i>Areas covered:</i> household size, economics, decision makers in household, gender norms, justification of wife-beating, issues to relational control, socio-demographic characteristics | Quantitative method 2002 Eritrea demographic and health survey Data analysed using multivariate logistic regression analysis | The odds of supporting the continuation of FGM were greater amongst women who justified wife beating (AOR 1.43; 95% CI=1.23–1.66). Among women who participated in household decisions, the odds of them supporting the continuation of FGM were less than among women who did not participate in household decisions (AOR 0.87; 95% CI= 0.75–0.99). | 83 |
| Tamire, M. and Molla, M. (2013) Prevalence and belief in the continuation of female genital cutting among high school girls: a cross - sectional study in Hadiya zone | n=780 aged 13–25 years (mean=16.2 years) Multi-stage cluster sampling Southern Ethiopia | <i>Aims:</i> to assess the prevalence and belief in the continuation of FGC among high school girls in Hadiya zone. <i>Areas covered:</i> age, residence, grade, religion, ethnicity, parental educational status, parental status, intention to continue practice | Self-administered questionnaire Data analysed using bivariate and multi-variate analysis | 9.4 % of circumcised girls supported their status as a circumcised girl, 5% believed in the continuation of FGC. The odds of being cut was higher among girls whose fathers and mothers had educational status under high school level (AOR=2.04; 95% CI=1.25-3.09) and (AOR=1.84; 95% CI=1.01- 3.38) respectively when compared to those whose parents had attended high school and above. The odds of believing in the | 91 |

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| | | | | <p>continuation of FGC was 2.33, 95% CI=1.01-5.33) times higher among those who responded that FGC was practiced in their areas.</p> <p>Female from rural areas were more likely to believe FGM should continue (AOR=2.31).</p> | |
| <p>Ahaonu, E. L., and Victor, O. (2014)</p> <p>Mothers perception of female genital mutilation</p> | <p>n=95 aged between 20-44 years</p> <p>92.6% married</p> <p>67.4% Christian</p> <p>32.6% Muslim</p> <p>Convenience sampling method</p> <p>Nigeria</p> | <p><i>Aims:</i> to investigate perceptions of FGM among mothers</p> <p><i>Areas covered:</i> demographic influences, education, religion, ethnicity, occupation</p> | <p>Quantitative method</p> <p>Semi structured questionnaires</p> <p>Data analysed using a chi-square test</p> | <p>Mothers had ambivalent about beliefs in the practice. 44.2% thought uncircumcised girls would be promiscuous. 30.5% believed FGM promoted female faithfulness to husband.</p> | 68 |
| <p>Yasin, B. A., Al-Tawil, N. G., Shabila, N. P., and Al-Hadithi, T. S (2013)</p> <p>Female genital mutilation among Iraqi Kurdish women: a cross-sectional study from Erbil city</p> | <p>N = 1987 aged between 15 – 49 (mean = 27.6)</p> <p>Convenience sampling method</p> <p>Iraq (Asia)</p> | <p><i>Aims:</i> to determine (i) the prevalence of female genital mutilation among Muslim Kurdish women in Erbil city, (ii) the patterns and types of female genital mutilation, (iii) the factors associated with this practice and (iv) women's knowledge and attitudes towards this practice.</p> <p><i>Areas covered:</i> social change and tradition, dictate of religion, libido, cleanliness, appearance, perceptions of</p> | <p>Quantitative method</p> <p>Structured interview administered questionnaire</p> <p>Data analysed using univariate logistic regression</p> | <p>The practice of FGM was significantly associated with the employment status of the women, FGM status of their mothers and education status of their fathers. The practice was reported more amongst housewives (adjusted AOR=3.3, 95% CI=1.8-6.1), those women whose mothers were mutilated AOR = 15.1, and 17.1% of non-mutilated participants.</p> | 83 |

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| | | FGM, intention to continue practice, knowledge and attitudes towards FGM | | | |
| Modrek, S. And Liu, J. (2013) Exploration of pathways related to the decline in female circumcision in Egypt | N = 17,579 (mean age of 12.7 years) Pre-existing data-set used Egypt | <i>Aims:</i> to understand the factors related to the decline in FGM in Egypt <i>Areas covered:</i> socioeconomic development, social media, women's empowerment, maternal education | Quantitative method Egypt Demographic and Health Survey Data analysed using logistic regression | Mothers' characteristics were associated with daughters' likelihood of being circumcised; strongest predictors included circumcision status, religion, age at first marriage, education | |
| Child Marriage | | | | | |
| Hossain, G., Mahumud, R. A., and Saw, A. (2016) Prevalence of child marriage among Bangladeshi women and trend of change over time | n=16,200 Pre-existing data-set used Bangladesh | <i>Aims:</i> to determine the prevalence, and factors associated with, child marriage among Bangladeshi women <i>Areas covered:</i> socio-demographic information, economical factors, education level, health and life style information. | Quantitative method Bangladesh Demographic and Health survey (BDSH 2011). Analysed using multiple binary logistic regression | Uneducated women were more likely to be married early (wald=624 (3), $p<0.001$). Child marriage was higher among women with uneducated husbands (wald=55.54 (3), $p<0.001$). Muslim women were more likely to marry early (wald=127.79 (1), $p<0.001$). Women from poor economic backgrounds were more likely to marry early (wald=51.30 (2), $p<0.001$). | 80 |
| Nasrullah, M., Zakar, R., Zakar, M. Z., Abbas, S., Safdar, R., Shaukat, M., and Krämer, A. | n=19 aged 21-34 years Participants were 1) was married | <i>Aims:</i> to describe women's knowledge and attitude towards child marriage practice who themselves were married as children in | Qualitative method In-depth semi-structured interviews | Key themes participants were not aware of the negative health outcomes of child marriages, negative outcomes of child marriages included medical | 86 |

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| (2014) Knowledge and attitude towards child marriage practice among women married as children-a qualitative study in urban slums of Lahore, Pakistan | before the age of 18 years (child marriage) 2) married for at least 5 years, and 3) had at least one childbirth. Pakistan | urban slums of Lahore, Pakistan. <i>Areas covered:</i> socio-economic status, education, occupation, age at marriage, intention to marry daughters, perceptions of child marriage and understanding | Analysed using thematic analysis | grounds and social relations, considered parents had made right decision to marry them young, half participants intended to marry their daughters young. | |
| Uddin, E. (2015) Family socio-cultural values affecting early marriage between Muslim and Santal communities in rural Bangladesh | N = 585 couples age range between 10-45 years for wives, 12 – 48 for husbands. N = 295 were Muslim and n = 290 were Santal Cluster sampling from the Talonda of Rajshahi district, Bangladesh. | <i>Aims:</i> to examine and compare how family socio-cultural values and its practices exert effect on early age at first marriage between Muslim and Santal couples in rural Bangladesh. <i>Areas covered:</i> ethnicity, family patterns, religion, residence, education, occupation, | Quantitative method Interview method with semi-structural questionnaire in family setting. Data analysed using Chi Square | Early age at first marriage was significantly ($p<0.01$) associated with family socio-cultural values; husbands' illiteracy ($X^2=82.65, p<0.01$); wives illiteracy ($X^2=72.29, p<0.01$); family pattern ($X^2=12.67, p=0.05$), residence pattern ($X^2=16.70, p<0.01$). | 80 |
| Ghosh, B. (2011). Child marriage, society, and the law: A study in a rural context in West Bengal, India | n=380 including fathers, mothers, daughters and elders. Random sampling India | <i>Aims:</i> to understand factors leading to the continuation of the practice of child marriage in order to explore social policy <i>Areas covered:</i> economic status, literacy status, family size | Qualitative method Focus groups Thematic analysis | Key themes: patriarchal trends, social customs, poverty, illiteracy of parents, education, communication, fear of elopement, lack of awareness, family size. | 72 |
| Matlabil, H., Rasouli, A., Behtash, H. H., Dastjerd, A. F., and Khazemi, B. (2013) | N = 60 Random sampling method | <i>Aims:</i> to determine the cause of the marriage under 18 years | Qualitative method Semi - structured interviews | Key themes: following the village culture and social pressure; economic issues; lack of awareness about side effects of | 77 |

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|---|------|--|--|--|--|
| Factors responsible for early and forced marriage in Iran | Iran | <p>in the Hervi village of Tabriz city in Iran</p> <p><i>Areas covered:</i> opinions about marriage and the appropriate time; age of marriage for girls in the village; factors affecting girl's marriage (family obligation and desire of girls); effect of levels of literacy and knowledge on marriage and cohabitation; information about dangers of early and enforced marriage; lifetime aspirations</p> | <p>Focus groups</p> <p>Thematic analysis</p> | <p>child marriage; negative attitude toward continuing of education in high schools; tend to marry young boys in early ages; freedom from undesirable and rigid rules of parents applying to girls; lack of access to high school in the area.</p> | |
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NB: AOR *adjusted odds ratio*, CI *confidence interval*, COR *conditional odds ratio*, OR *odds ratio*

1.3. Results

Study findings are discussed in line with the themes that emerged from a critique of the literature and in accordance with the aims of the study. Please refer to Table 1.2 for additional details about the studies reviewed.

1.3.1. *Aim 1: What are the sociological facets that perpetuate HTPs?*

The main sociological underpinnings for the continuation of child marriage, son preference, and FGM were categorised into the following themes; educational status, residential location, economic status, and family history of practising HTPs.

1.3.1.1. Educational status

Sixteen of the twenty-one studies examined revealed that a pertinent reason for the persistence of child marriage, FGM, and son preference lay in women's educational status. Using quantitative interviews, Chavada and Bhagyalaxmi (2009) identified 93.04% of women in India who showed a preference for the male child, were illiterate. However, although this relationship was statistically significant, the use of a cross-sectional design meant causality could not be predicted. Furthermore, the design method established attitudes only and did not allow prediction of behaviour consistent with son preference.

Lei and Pals (2011) further noted higher educational attainment in women reduced the likelihood of having a son preference. The use of a standardised household survey in this study was beneficial because unlike Chavada and Bhagyalaxmi (2009) it allowed for retrospective and prospective analysis of changes in son preference over time. However,

the use of secondary data meant concepts pertaining to the study's research aims could not always be attained.

Of note is Diamond-Smith, Luke, and McGarvey's (2008) qualitative study that revealed key to the persistence of female infanticide consequential to son preference, was knowledge and education relating to availability of sex-selective abortion and female infanticide. This study emphasised that women who were educated about ways to have sex-selective abortions were more likely to engage in these practices compared to those who were unaware there was a way, albeit an illegal way, that they could control the sex of their child. This study highlighted the complex influence of education level, which was not considered in other studies.

Consistently, several quantitative studies that were reviewed (Karmaker, Kandala, Chung, & Clarke, 2001; Mohammed, Hassan, & Eyada, 2015; Tamire & Molla, 2013; Dehghankhalili, et al., 2015; Ahaonu & Victor, 2014; Modrek & Liu, 2013) showed low education significantly predicted FGM status. It is noted however that the statistics reported in Modrek and Liu's (2013) study do not provide enough information to enable effect size to be determined.

Conversely, Tamire and Molla's (2013) cross-sectional research amongst high-school girls, showed that despite 31.1% of girls having mothers who were illiterate, and 26.8% having no formal education, 90.6% of girls supported the discontinuation of FGM. All girls in the sample were attending school, implying that education decreased intention to continue FGM. What remained unclear however were the mechanisms underpinning how education reduced intention to continue FGM. The results demonstrated intent to discontinue FGM but did not predict action. Additionally, findings did not consider

parental education status in tandem with daughter's education status and thereby ignored the influence of familial pressure over a daughter's decision to continue FGM. The role of family influence is highlighted in the qualitative studies of Nasrullah, et al., (2014) and Ghosh (2011), where girls of parents with a lower education were more likely to be married young. As marriage at a young age is associated with poor access to education, these studies highlighted poor education as a factor in enabling the continuation of HTPs.

Further quantitative studies by Hossain, Mahumud, and Saw (2016) and Uddin (2015) found low education in women and girls was a significant predictor of marriage before the age of 16 years. The use of semi-structured surveys in Uddin's (2015) study posed limitations as its methodological stance opposed the binary analysis used. It was stated in the same study that due to illiteracy, many participants were unable to understand the questions asked of them resulting in researchers probing to elicit answers. This approach could be construed as attempting to pigeonhole participants into giving a particular response, potentially skewing the data.

It was also noted by Matlabil, Rasouli, Behtash, Dastjerd and Khazemi (2013) that negative attitudes toward girls continuing high-school education was key in influencing the persistence of child marriage. However, the use of focus groups, although producing interesting themes, may have also yielded bias with participants possibly tending to conform to socially desirable responses.

Consistent across studies was how low education levels aided persistence of son preference, FGM, and child marriage. However, of note was the limited use of qualitative studies that sought to better understand this relationship.

1.3.1.2. Residential location

All six studies that assessed the impact of residence focussed on the differences between urban and rural areas. Results suggested that women residing in rural areas were more likely to perpetuate HTPs.

When considering persistence of son preference, two quantitative studies (Chavada & Bhagyalaxmi, 2009; Lei & Pals, 2011) found women living in rural areas of India and China, respectively were more likely to have a preference towards having a male child. Conversely, Kapadia, Parikh, Patel and Bharucha (2015), who used a structured interview method, found that in the Ahmedabad district in India, son preference was more prevalent in urban areas. This suggested some inconsistency within the research when deliberating the role of residential status in the perpetuation of son preference. Notably, Kapadia et al. (2015) further revealed that reasons for son preference differed between urban and rural areas. However, this study's use of Chi-square tests meant that in order to generate expected frequencies, assumptions were made that half the women in rural and urban areas would have a son preference and half would not. When analysing data, this could have resulted in a type-1 error meaning results were inaccurately considered significant.

Three quantitative studies (Karmaker et al., 2011; Mohammed et al., 2015; Tamire, & Molla, 2013) found women who resided in rural areas were significantly more likely to have had FGM or be willing to practice FGM on their daughters, relative to those residing in urban areas. The study by Karmaker et al. (2011) was particularly advantageous in understanding the association between residential location and engagement with HTPs due to its notably large sample size and high response rate. However, the topic area encompassed complex social and political contexts and as noted by the authors, responses based on self-report may have been subject to social acceptability bias. Moreover, all three

aforementioned quantitative studies bore correlational data resulting in an inability to infer causality between residential status and continuation of HTPs.

One quantitative study investigating the persistence of child marriage (Uddin, 2015) found that women who inhabited rural areas were significantly more likely to marry young or wished to marry their (daughters' young. While this study has been broadly supported cross-culturally, the use of Chi-square analysis did not allow inferences to be drawn regarding other socio-demographic factors that may influence and mediate child marriage in rural areas.

1.3.1.3. Economic factors

Ten studies identified the impact of economic status on the perpetuation of the three specified HTPs. The manner in which economic factors were influential differed across the different typologies of HTPs.

Within the context of son preference, findings revealed two core concepts underpinning economic factors; the first related to the economic utility of a male child, and the second related to the additional expenditure of the female child. To consider the former, Chavada and Bhagyalaxmi (2009) and Kapadia et al., (2015) identified that a son's ability to provide an income and support their elders in old age was a significant reason behind the partiality to have a male child. With consideration of the latter factor, Kapadia et al., (2015) and Diamond-Smith et al., (2008) identified the most common reason for daughter aversion was concern regarding the expense of dowry payment. Respondents in the study by Diamond-Smith et al., (2008, p.6) stated that not being in a financial position to pay a dowry influenced preference for a male child:

With a boy there is no need to give a dowry and all those things are expensive after they [girls] grow up.

It was also identified that being unable to pay a respectable dowry meant the welfare and safety against violence towards daughters could not be guaranteed.

The role of economic factors was also evident in studies relating to FGM (Karmaker et al., 2011; Ashimi & Amole, 2015; Besera & Roess, 2014; Yasin et al., 2013) that found women from lower classes or who were unemployed were more likely to practice FGM comparative to those in higher social classes. However, as in the study by Ashimi and Amole (2014), women were not examined to assess FGM status and the author relied on participant self-identification. Consequently, responses may have been the result of social desirability bias. Furthermore, while this and other studies indicated the economic status of women was a contributory factor to the perpetuation of FGM, as the reasons for the practice of FGM were not examined in this study, results regarding economic status are correlational and fail to consider extraneous variables.

Continuation of child marriage was also argued to have economic roots. The quantitative studies of Hossain et al., (2016) and Uddin (2015) demonstrated that girls were more likely to be married as a child if their family had a lower economic status. The use of linear regression to analyse the results in the study of Hossain et al. (2016) implied the relationship between age of marriage and economic status was linear. However, when considered in conjunction with results of Uddin's (2015) study, there were other factors, including religion, residential location, ethnicity, family pattern and illiteracy, that also influenced the impact of economic status and could therefore act as mediating factors.

To consider economic status in isolation limits the explanatory value of the Hossain et al. study.

Economic factors were emphasised also by Matlabil et al.'s (2013, p.228) qualitative study whose respondents expressed that early marriage to a wealthy groom could guarantee their future away from their current unstable economic situations: "...you'll be lucky to marry this person because of his financial position...I wish".

1.3.1.4. Family history of harmful traditional practices

Pertinent across reviewed studies was the persuasive role that family history of HTPs had on their persistence. Within this context, family history referred to whether or not there was a maternal record of HTPs being carried out by and/or against mothers or grandmothers. With no studies documenting the role of a family history relating to son preference, it appeared this facet was most influential within FGM and child marriage.

Four studies investigated the persistence of FGM within the context of family history. Karmaker et al., (2011) identified that women who had themselves had FGM increased the likelihood of them continuing the practice if they were of an older generation; however, this was not true for younger generations who had undergone FGM. Dehghankhilili et al., (2015); Mohammed et al., (2014) and Yasin et al., (2013) expanded this, showing a positive correlation between a history of FGM in a mother, grandmother, or older sister, and continuation of the practice. This finding was supported by the qualitative study by Abdelshahid and Campbell (2014) that identified continuing FGM was important for carrying on family honour.

Akin to Abdelshahid and Campbell's (2014) findings, Ghosh's (2016) study was particularly helpful in understanding the role of family history in the continuation of HTPs. By conducting in-depth interviews and focus groups with three generations of families - grandmother, mother and daughter - it was evident that stories told by elders regarding their own early marriage created a moral standard to which younger members of the family were pressured to adhere to in order to continue family honour thereby, highlighting the unspoken powerful influence of elders within a community in the continuation of HTPs. It is noted however that whilst the use of focus groups in the study allowed for inclusion of a large number of participants, responses may have been consequential to conformity to social pressure for fear of social reprisal.

Whilst these studies demonstrated a familial passing down of HTPs, as discussed in section 1.3.2.1, personal experience of a HTP can also act as a resistance to it.

1.3.2. *Aim 2: What are the factors facilitating resistance to the continuation of HTPs?*

The systematic review identified two key themes relating to factors that assist defiance against HTPs including negative health consequences and female autonomy.

1.3.2.1. *Negative health consequences*

A central theme from the critique of the studies was the impact of negative health consequences on increased likelihood to resist HTPs. Negative health implications were not noted in the reviewed literature as a reason to stop practices relating to a son preference: however, four studies into FGM and child marriage highlighted findings in this area.

Ashami and Amole, (2015) found that women who were aware of the physical health risks of FGM were less likely to continue the practice, with principal health-related fears being HIV, fistula, infection and childbirth complications. Although Ashami and Amole's (2015) study only allowed for attitudes rather than behaviours to be understood, their results were corroborated by the qualitative study of Abdelshahid and Campbell (2015, p.60), that showed women's direct experience of the negative health consequences of FGM would prevent them continuing the practice and wrote:

...that day my daughter fainted, it was an awful day, thank god she survived. I didn't want to go through the same experience with my other two daughters.

This study allowed both resisting attitudes and behaviours towards FGM to be understood, thereby providing useful insight into how understanding the negative health consequences increased attitudes and behaviours that opposed FGM. However, it is noted that verification of daughters FGM status to ensure resistance, was not possible in this study. Therefore, responses could have been consequential to the increased implementation of FGM legislation in Egypt, which led to the first prosecution in 2013, a year prior to data collection in this study.

Congruently, Tamire and Molla's (2013) study showed those who believed FGM was not harmful had increased intent to continue the practice on their daughters.

The qualitative study of Nasrullah et al., (2014, p.4) found that some women considered there to be negative health implications when married young and stated:

Early marriages most often result in conflicts, divorce, 'husband' violence, and health issues for the females. Those girls who get married in later age are better ones; ...I have witnessed so many hardships [health] and troubles just because of my child marriage. I will never let my daughters face those hardships and will not marry them in their childhood.

Whilst this showed the influence of understanding the negative health impact of child marriage on resistance of HTPs, the small sample size used, as well as the select geographical area from which these participants were recruited, reduced the extent to which results represented the attitudes of women in other areas.

1.3.2.2. Female autonomy

Female autonomy was a recurrent theme relating to the discontinuation of HTPs, with three studies revealing that in families where the females had increased levels of autonomy, there is a heightened likelihood of resistance to HTPs.

Besera and Roess (2014) showed lower levels of autonomy in women were associated with the continuation of FGM, with the odds of supporting continuation being greater amongst women who justified wife-beating (AOR 1.43; 95% CI=1.23–1.66) and in women who did not participate in household decisions (AOR 0.87; 95% CI=0.75–0.99). This study is one of the few that looked at the role of women's autonomy and its results are particularly helpful in understanding this correlation. However, as noted by the authors, the cross-sectional study design implemented may have resulted in reverse causality, with women who actively opposed FGM being ostracised within the community, thereby reducing their autonomy. This could have affected the reliability of the results. Use of the Demographic and Health Survey also meant questions asked did

not necessarily pertain to women's interests; instead, questions related to decisions that women were entrusted to make, thereby reducing the validity of the study. Finally, questions only measured women's participation and did not consider the influence their contribution had over decision outcomes.

Karmaker et al., (2011) found in households where men had more autonomy over women with respect to household and health decisions, both wives and daughters were significantly more likely to have undergone FGM indicating that where women had less autonomy, they were less able to resist HTPs. These results were substantiated by Ghosh's (2011) field study that found elder males tended to dictate the activities within a family, with women who perpetuated child marriage having little association with the outside world and thus little autonomy with decision-making.

1.3.3. *Aim 3* - What are the control mechanisms that inhibit resistance to HTPs?

Reviewed literature revealed three core control mechanisms that provided a framework for the perpetuation of HTPs inclusive of religion, tradition and patriarchy.

1.3.3.1. *Religion*

Eleven of the 21 studies considered the role of religion. Two quantitative studies regarding son preference found associations between preference for a male child and religion (Chung, 2007; Kapadia et al., 2015). Chung (2007) found that when comparing women of Christian, Buddhist, and Confucian religions, Christian women were less likely than Confucian women to have an induced sex-preference abortion, whereas Buddhist women did not differ in their practice of sex-selective abortion to Confucian women. The

study revealed that despite differing degrees of influence, religion was a strong driving force behind the continuation of son preference. The use of multivariate logistic regression in this study was advantageous as no assumptions were made about the distribution of the data; however, it did not allow for understanding regarding how religion influenced son preference. Furthermore, where a woman reported having a still-born female child, it was unclear if this was consequential to actions to abort the child prenatally, or due to natural causes.

When comparing Muslim, Jain, and Hindu religions, Kapadia et al. (2015) found religion to be an influencing factor, particularly in the Muslim faith, with 100% of Muslim participants indicating a son preference comparative to 87.05% of Hindu participants.

Five quantitative studies found a relationship between religion and continuation of FGM (Karmaker et al., 2011; Mohammed et al., 2014; Ashimi & Amole, 2015; Tamire & Molla, 2013; Dehghankhalili et al. 2015). Karmaker et al., (2011) found religion had a significant impact on the likelihood of having had FGM, with those of the Muslim faith (83.6%) being proportionately more likely to have undergone FGM compared to those who were Catholic (67.0%) or Protestant (61.8%). Additionally, those who identified as being Muslim were more likely to have had their daughters circumcised (35.2%), compared to Catholics (32.6%) and Protestants (15.5%). However, the articles revealed this was mediated by age and education with highly educated Catholics and Protestants being less likely to have had FGM. No such mediating factors were found for those who practiced Islam. Younger age groups across all religions were less likely to have practised FGM on their daughters.

Mohammed et al., (2014) also identified religion as a motivational factor behind the continuation of FGM, with 89.8% of Muslims with type-1FGM, and 45.2% with type-2, identifying religion as their rationale for continuing its practice. However, despite its large national sample, this study failed to consider FGM types 3 and 4, thereby limiting the generalisability of the results.

Consistently, Ashimi and Amole, (2015) and Tamire and Molla, (2013) found religion to be within the most prevailing reasons for FGM. However, this was only corroborated by 2.7% and 16.6% of their sample, respectively, with other factors being identified as more important. Thirty percent of participants in the Dehghankhalili et al. (2015) study, all of whom were Muslim, identified religion as the reason for their practice of FGM. However, the cross-sectional design used meant causality between religion and continuation of FGM could not be inferred. Furthermore, interaction between religion and other socio-demographic factors was not considered.

Two qualitative studies found religion to be a mechanism behind FGM. Bogale et al. (2014, p.5) emphasised the nexus between the two facets and stated:

In our religion, anybody reaching 15 years of age be it boys or girls are expected to have ‘Sollat’ (praying) five times a day. This is possible for a girl if and only if she undergoes circumcision. Her ‘Sollat’ is not accepted by Allah unless she is circumcised.

The mixed-method approach of this study was advantageous as it allowed thorough understanding of the influence of religion on continuation of FGM. However, in terms of limitations, the researchers asked about topics they considered non-sensitive in a focus-

group setting, whilst issues they considered sensitive were asked in an individual interview, without giving the participants a choice over the method of interview utilised. Consequently, responses may have been prone to demand characteristics and social desirability.

Abdelshahad and Campbell (2015, p.58) found conflicting evidence, with women stating they were unsure if religion was a reason to continue FGM:

Regarding religious law, I'm now 45 and I still don't know; some people say its haram [religiously forbidden] and other say its halal [acceptable within the religion]

Two quantitative studies about child marriage investigated the role of religion. Hossain et al., (2016) found women from the Muslim religion were significantly more likely to both be married young and consent to their daughter's child marriage comparative to those of other religions. However, the denominations of other religions were not made explicit within this study, and the sample was principally from the Muslim faith, thereby limiting the generalisability of the results. Conversely, Uddin (2015) identified that in Bangladesh, the average age of marriage for a Muslim woman was 21.12 years, comparative to 19.69 years for women in the Santal religion.

1.3.3.2. Culture, Tradition, and social pressures

Eleven articles revealed a relationship between cultural or traditional values, social pressure and the continuation of HTPs.

Within the context of son preference, Diamond-Smith et al. (2008, p.8) identified societal pressure meant women were more likely to display a preference for a male child and engage in female infanticide and one participant stated:

There is lots of outside pressure from midwives and such. They come and if they see that you have a large family they get on your case, saying 'How dare you have so many children? Do you think you can raise all these children?' There is a lot of pressure (because) there is the dowry. Also when you have too many girl babies there is female infanticide.

It was noted by the authors that no question in this study was asked directly about female infanticide; however, it was raised repeatedly by participants, suggesting its' occurrence was commonplace within Tamil Nadu, India. However, results may not be representative of other African and Asian cultures.

Mohammed et al., (2014) and Yasin et al. (2013) further highlighted that 100% and 46.6% of participants respectively, considered social and cultural tradition as a motivational factor to continue the practice of FGM, with older women particularly emphasising societal pressure and norms as the rationale behind their attitudes in favour of its continuation.

However crucial to note is the absence of women from rural areas in the Yasin et al. (2013) study thereby making the sample non-representative of communities who practice FGM. Furthermore, the use of a cross-sectional design in this study prevented predictive validity across time periods.

Consistent findings were also identified in Ashimi and Amole's (2015) study where 34.4% of participants believed FGM should be continued in the name of tradition, as well as the study of Bogale et al. (2014), in which 74.8% of participants believed in the continuation of FGM for social acceptance. Dehghankhalili et al. (2015) corroborated these findings, showing 57.1% of participants considered ancient tradition as a reason for continuation of FGM, in line with Tamire and Molla's (2013) study that found school girls believed FGM should continue to avoid shame and stigma (36.6%) and to respect culture (25.0%). Tamire and Molla's (2013) study also emphasised the odds of believing FGM should be continued was 2.33 times higher for individuals who reported that FGM was practised in their residential area, indicating a social pressure to conform to socially desirable conventions.

The above findings were further substantiated by Abdelshahid and Campbell (2014, p. 58) where qualitative interviews found cultural norms were a reason for carrying on FGM and wrote:

It all depends on community norms, if everyone is circumcising their daughters, we'll circumcise our daughter; if they aren't, we won't circumcise her, that's normal.

The role of societal pressure was also highlighted by emphasis on the ridicule a girl would receive if she did not have FGM:

Of course family members will deride her and humiliate her, even her colleagues and cousins they'll fight with her and tell her "you aren't circumcised, you aren't good".

Similar findings were noted in studies addressing epidemiology of child marriage. The qualitative studies of Nasrullah et al. (2014) and Matlabil et al. (2013, p.228), found culture and social pressure were noted as the dominant reasons to marry a child young and one participant stated: "It [child marriage] is a tradition and it should be continued". This supported Ghosh (2011) who identified 1–6% of women considered continuation of child marriage to be rooted in social customs.

1.3.3.3. Patriarchy

The concept of patriarchy was prevalent across 9 of the 21 studies reviewed. Although son preference is innately patriarchal, two studies emphasised that patriarchal beliefs were an underlying mechanism in its perpetuation. Chavada and Bhagyalaxmi (2009) noted that rationale for son preference was attributed to patriarchal reasons inclusive of dowry problems (13.64%) and girls not staying with parents (17.21%), whilst Lei and Pals (2011) found that gender role beliefs about the superiority of males was a significant predictor of son preference, with an emphasis on sons being heir to family property and in times of economic downturn, women should be expelled from the house first.

Six reviewed studies argued that patriarchy underpinned the practice of FGM. Mohammed et al. (2014) and Bogale et al. (2014) showed 100% of participants considered FGM to be for the purposes of marriage and to conserve virginity, consistent with Adewale and Amole (2015) who noted FGM as improving marriageability. Bogale et al.

(2014) also found the purpose of FGM was to comfort men during sex, a facet also highlighted by Tamire and Molla (2013). Consistent with these findings, Ahanonu and Victor (2014) argued that FGM was a mechanism to reduce unfaithfulness to husbands. However, this study only used participants from one health care centre and the findings cannot be generalised. Questions were in English and, for many participants, these had to be translated, which may have distorted the meaning.

Abdelshahid and Campbell (2014, p.54) argued that FGM was a form of sexual control to aid the prospect of marriage, with one participant stating:

My duty is to bring her [daughter] to her future husband intact, without having committed any wrongdoing or had any sexual relationship.

Additionally, both Nasrullah et al. (2014) and Ghosh (2011) argued that across all members of society, child marriage was considered 'essential' for girls.

1.4. Discussion

The aim of this review was to critically appraise both quantitative and qualitative research regarding son preference, FGM, and child marriage within the framework of the literature review aims. The following sections discuss these findings.

1.4.1. Summary of results

Critique of the literature has revealed a number of key themes regarding the practices of son preference, FGM, and child marriage. When considering sociological factors that

perpetuate HTPs, educational status of women, residential location, economic status, and a family history of practising HTPs were all identified as central.

The lower education status of women perpetuating HTPs was significant across the reviewed studies and is consistent with other research (Jain & Kurz, 2007). Interestingly, whilst educational programmes have been initiated and shown to have some success in relation to FGM (Mounir, Mahdy, & Fatohy, 2003), as well as child marriage (International Centre for Research on Women, 2007), there is limited evidence to suggest that such educational programs exist in an attempt to eradicate son preference. Studies reviewed did not consider the relationship between educational status and other socio-demographic factors that may prevent the effectiveness of educational programmes.

Noteworthy is that whilst the predominance of studies reviewed focussed specifically on the educational status of women, Hossain et al., (2016) demonstrated that the educational status of a husband influenced women's intention to continue HTPs. Specifically, continuation of child marriage was associated with lower levels of male education.

All but one study which investigated residential status and persistence of HTPs, found that child marriage, son preference, and FGM were more common in rural areas. Due to the chi-square and logistic analysis methods used in the predominance of reviewed quantitative studies, the interaction between residential location and education could not be attained. However, based on studies that show education is lower in rural areas (World Bank, 2008), it can be speculated that residential location is related to women's access to education opportunities.

When considering factors that aided the resistance to HTPs, the review identified female autonomy and negative health consequences as key themes. The association between increased female autonomy and reduced gender-based violence has been highlighted consistently in other research (Khawaja, et al 2008). Increasing female autonomy empowers women and girls, thereby strengthening resilience.

The review revealed that patriarchal values negatively affected resistance to HTPs. The studies demonstrated sexual control and marriageability of women as key instruments adhering to patriarchal systems. This is consistent with Sexual Control Theory which asserts HTPs against women are carried out as a method to control women's sexuality to ensure the purification of girls, thus making them eligible for marriage (FORWARD, 2010). FGM and child marriage have therefore been intrinsically linked with preserving girls' virginity for the benefit of men (Dorkenoo, Morison, & Macfarlane, 2014).

Other studies in the review also lend support for this, with lower levels of women's autonomy leading to a reduced ability to resist harmful traditional practices. This is consistent with research by Wadesango, Rembe, and Chabaya, (2011) that highlighted underpinning numerous HTPs, lie deeply entrenched discriminatory belief systems and values about the position and function of women within society. Within this context, HTPs serve to perpetuate the subordination of women and legitimize gender-based violence.

Emphasis on women's purity in the name of religion and/or culture has economic implications. A critique of qualitative and quantitative research allowed a deeper understanding of how economic factors influenced decisions to continue HTPs, with studies indirectly alluding to patriarchal values that denigrate the value of women who

may be viewed as commodities that can be exchanged for economic worth. In the case of FGM and child marriage, ensuring a girls' virginity provided increased opportunity for financial gain, with women who are 'pure' being more desirable for marriage and therefore valued as being worth a higher dowry (UN Women, 2013). Furthermore, the current review highlighted that son preference was increasingly rife in impoverished families, as bearing a son was considered more financially profitable.

The articles reviewed highlighted religion, social and cultural influences as methods of control to ensure perpetuation of HTPs. This is consistent with wider literature that argues religion and culture play an irrefutable role in the heritage of HTPs as a method of disempowering women, with many acts of violence against women being carried out using 'culture and religion' to justify their practice (United Nations Secretary General, 2006). Wyteenbach (2008, p.229) states:

Religion, culture, and tradition are [malleable] constructs, which can be defined, used and (re)-interpreted depending on the interests involved.

Therefore, both are susceptible to patriarchal interpretations that ensure and reinforce male domination within a given society (Shaheed, 2008).

Based on the research findings of Modrek and Liu (2013), it is argued that there is an association between the age of a mothers first marriage with their intention to practice FGM on daughters. Mothers who married younger were also more likely to have had FGM themselves. Additionally, both Modrek and Liu (2013) and Chung (2007) stated that women with a larger age differential between them and their husbands were likely to perpetuate FGM and have a preference for the male child. It is therefore argued that

children who are married at a young age, to an older man, are more susceptible to having both experienced HTPs, and perpetuating them.

Whilst themes of cultural tradition, sexual morals, marriageability, religion, health benefits, and male sexual enjoyment as reasons for the persistence of FGM are consistent with the findings of Berg and Denison, (2013) the current review unearthed no mention of the illegality of FGM or any other practice as a reason for its termination. This current review argues the implementation of state legislation is not effective in Africa and Asia, as is often the case with other practices of sexual and gender-based violence (Thorpe, 2014).

1.4.2. Clinical and policy implications

The review highlighted the increased risk of children who marry young perpetuating the practice of HTPs, therefore it is argued that in order to address FGM and son preference, society needs to first tackle child marriage.

The review also highlighted that the disempowerment of women through reduced access to education, in addition to other factors, underpins the perpetuation of HTPs by reducing women's autonomy and their knowledge of the impact of HTPs. Consequently, services need to promote strategies and programmes that empower women internationally. As government programmes have revealed limited effectiveness, the greater use of non-state and community-based programmes, that involve local communities and leaders, including religious organisations, would perhaps be more effective in tackling their eradication.

As patriarchal values appear to inhibit social change against HTPs, introducing gender-integrated approaches that empower women and girls, alongside engaging males, will be fundamental in strengthening women's resilience and challenging deeply entrenched social norms that perpetuate gender inequality (Mercy Corp, 2014).

1.4.3. Limitations and future research directions

Methodological problems within the reviewed studies were apparent due to the use of household surveys in isolation from other measures. Although using questionnaires was useful to assess the relationship between the occurrence of HTPs and demographic factors such as education, residence, economic status, religion and occupation, they fail to explain why these factors are influential. Furthermore, use of chi-square analysis in some of the quantitative studies in the review, whilst showing a relationship between the tested variables, failed to provide substantive information regarding the strength of the relationships or their fundamental significance in the population. It was also noted that statistics reported within some of the reviewed quantitative studies did not provide enough information to allow for comparison of effect sizes. Therefore, it could be helpful if future research sought to use a mixed-methods approach to understanding both the reasons for the continuation of HTPs as well as providing further in-depth information regarding individuals' attitudes regarding these practices.

The self-report approach used in many of the studies also meant that many responses were subject to social desirability biases. Whilst this was acknowledged by some articles, many failed to consider the influence of social structures and legislation on participant's responses. Further in-depth qualitative research carried out by non-government organisations or community organisations that survivors trust may provide valuable

information on this issue, as well as those programmes and support structures that women find helpful.

An additional limitation of this review could be its deliberate focus on only women participants. As identified in the review, patriarchy, gendered inequalities and gender roles serve as central mechanisms of control, thus by failing to consider the role of men it is unclear how their attitudes influenced and interacted with the attitudes of women. Further research into the perceptions of men, gendered inequalities and gender roles that perpetuate the practices of HTPs would be helpful to gain a greater understanding of these issues.

As all the studies used in the review focussed solely on either Africa or Asia, making generalisations across differing countries in which HTPs are practised was difficult. Future research could address this through the use of cross-cultural research and quantitative comparative studies that incorporate a wider number of countries and explore the specific factors that perpetuate these practices within different contexts.

As the review progressed, the complexity of the subject due to the vast and varying number of variables became apparent. Whilst the studies identified factors increasing the risk of HTPs being continued, and mechanisms facilitating their protraction, the research tended to look at these issues in isolation rather than assessing how the variables perpetuating HTPs inter-relate. Future research could seek to ascertain the relationship between the variables underpinning HTPs, how they are inter-related and how they differ cross-culturally.

Finally, as the implementation of state legislation appears ineffective in Africa and Asia, future research may seek to address why legislation making HTPs illegal does not appear to act as a deterrent to their continuation outside of Europe.

1.4.4. Conclusion

The current systematic review of qualitative and quantitative studies of HTPs in Asia and Africa has highlighted important core themes across son preference, FGM and child marriage. Whilst research to date has investigated HTPs in isolation from one another, this review has highlighted the need for increased research into the underlying reasons and complexities associated with these multiple practices in different contexts. The current review has emphasised the need for a more thorough understanding regarding the factors associated with the ineffectiveness of the state to implement legislation and for the role of non-state and community-based organisations in relation to these practices to be more fully understood and considered within the context of social norms.

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Chapter 2: Empirical Paper

Title: Psychological Impact of Female Genital Mutilation: A Grounded Theory Approach

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(See Appendix A for author guidelines and email from editor)

2.0. Abstract

Background: Whilst previous research has focused on the physical health consequences of FGM, there has been little consideration of the psychological impact of FGM, or the psychological impact of health complications. Previous research has tended to be quantitative, diagnostically driven, and lacking sufficient attention to gendered

frameworks, thereby often presenting survivors as victims, without women being given the opportunity to voice their views regarding how they understand the effects of FGM on their lives. **Aim:** The aim of the current research was to gain an understanding of women's experiences of FGM in order to develop a theoretical conceptualisation of the psychological impact of FGM. **Method:** Using a grounded theory approach, qualitative semi-structured interviews were carried out with 20 women survivors of FGM. **Results:** Women participant's related culture, religion, role of men, lack of education, female identity and deception as the major factors influencing their understanding and the impact of FGM. Their experiences of FGM, as well as being influenced by their conceptualisation of the practice, led to effects on their emotional life, relationships, identity, and physical body. The fear resulting from FGM that women described affected their ability to enhance their resilience. All of the core categories of emotional, relational, identity, and physical impact, as well as resilience, were further influenced by the key stages of womanhood; including menstruation, marriage and childbirth. Women voiced their views that all the above issues were compounded by their needs not being met and the lack of meaningful and effective service responses.

Key words: *Female genital mutilation, psychological impact, resilience, grounded theory*

2.1. Introduction

2.1.1. Female Genital Mutilation

Female Genital Mutilation (FGM), also referred to as 'female genital cutting' or 'female circumcision' "comprises all procedures that involve partial or total removal of the

external female genitalia, or other injury to the female genital organs for non-medical reasons” (WHO, 2016, p. 1). As suggested by this definition, there are differing types of FGM as described below:

Table 2.1: Definitions of FGM typologies

| Type of FGM | Definition |
|--------------------|---|
| Type 1 | Clitoridectomy: partial or total removal of the clitoris and, in very rare cases, only the prepuce |
| Type 2 | Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora |
| Type 3 | Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris. |
| Type 4 | Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping, and cauterizing the genital area. |

Whilst exact prevalence statistics of FGM are unknown, according to UNICEF (2016) data, an estimated 200 million girls and women worldwide have undergone a type of FGM. Globally, 3 million girls are at risk of being ‘cut’ every year (WHO, 2016). Although practised worldwide, it is most prevalent in 30 African and Middle Eastern countries. As a consequence of immigration and refugee movement, 60,000 girls born to mothers with FGM are now living in the United Kingdom, (UK) (Macfarlane & Dorkenoo, 2015). Although the UK’s Female Genital Mutilation Act (2003) makes conducting FGM an offence punishable by up to 14 years’ imprisonment, it is approximated that annually 20,000 girls in the UK are at risk of being cut (Yoder et al., 2004). This has particular implications for UK health care professionals (Girls Summit, 2014; Global Summit to End Sexual Violence in Conflict, 2014).

2.1.2. Psychological impact of FGM

Despite research evidencing the influence of childhood trauma on later psychological well-being, (Bebbington et al., 2011; Read et al., 2003) empirical research investigating the psychological impact of FGM is limited. Whilst many articles reference the concept of ‘emotional and psychological’ difficulties, (Mulongo, Martin, & McAndrew, 2014) this is rarely substantiated with empirical support.

Research that does provide empirical sustenance comes from Lockhat, (2004) who found following FGM many women reported feeling ‘sad’ and ‘as though something was missing’. Furthermore, Behrendt and Moritz (2005) showed 80% of circumcised women experienced flashbacks to having FGM, as well as having a significantly higher prevalence of Post-Traumatic Stress Disorder (PTSD) accompanied with memory difficulties (30.4%) and other psychiatric symptoms (47.9%) compared to uncircumcised women, who reported no PTSD and only 4.2% displayed other psychiatric symptoms. 80% of circumcised women also met the clinical criteria for affective and anxiety disorders.

These findings are substantiated by Kizilhan (2010) who found circumcised girls in Northern Iraq showed a significantly higher prevalence of PTSD symptoms (44.3%), depressive symptoms (33.6%), anxiety symptoms (45.6%) and somatic disturbance (35.7%) compared to uncircumcised girls.

FGM has also been found to cause a fear of future physical health complications (Lockhat, 2004; Insel & Rath, 2006; Lundberg & Gerezgiher, 2006), including difficulties

with conception. Horowitz and Jackson, (1999) argued this could impact on women's identity, as the ability to bear children is a defining element in womanhood.

Whilst research indicates that FGM can lead to psychological difficulties, studies have tended to apply a Westernised PTSD framework to the subsequent responses of survivors. Western models of trauma fit poorly with the local cosmologies, norms, and values within which women survivors make sense of their experiences (Boyden & Gibbs, 1997; Liebling-Kalifani, 2010; Wessells, 1999). A PTSD model views society as an integrated, self-equilibrating system in which FGM is considered to lie outside normal human experience (Allen, 1989; Boyden, 1994; Davis, 1992). However, for many women in different cultures, FGM is a normal part of societal life, perpetuated through community traditions. Imposing a Western trauma framework on non-Western populations creates ethical and imperial issues (LeVine, 1999). It is therefore important to try to create further understanding of the impact and meaning of FGM from the affected women themselves.

2.1.3. Resilience

The diagnosis of PTSD was initially designed for male military personnel; thus as a theoretical model fails to adequately highlight women's own gendered and collective experiences of FGM within its cultural context, thereby also neglecting to account for their resilience (Burstow, 2005; Liebling-Kalifani, 2010).

It has been argued that research has historically tended to focus on women's vulnerability as well as 'medicalisation of their distress' (Boyden, 2000; Liebling-Kalifani, 2009). This places women in a disempowered position implying helplessness. Placing greater

emphasis on culturally-sensitive frameworks provides a starting point that recognises people's capacities to deal with their experiences. However, no research exists on this subject in relation survivors' own views of FGM.

2.1.4. Psychological impact of physical health complications

Research has suggested that physical health complications that can arise from FGM have psychological effects. Short-term consequences include severe pain, excessive bleeding, shock, micturition difficulties, and infections, whilst long-term consequences include chronic pain, increased risk of infection, and increased risk of obstetrical problems (WHO, 2016; Berg et al., 2014).

Studies unrelated to FGM show long-term health conditions can increase the risk of psychological difficulties (WHO, 2006; Ahmed & Holtz, 2007; Mutambara et al., 2013; Craig, 2003; Bair, 2003), however to date, no research has investigated the impact of physical health complications of FGM on survivor's psychological health.

2.1.5. Rationale for current research: aims and research questions

As stated above, the majority of existing research with FGM survivors had tended to be quantitative, diagnostically driven and lacking sufficient attention to gendered frameworks. Furthermore, women are rarely given the opportunity to voice their in-depth views regarding how they understand the impact of FGM on their lives. The current research therefore aimed to fill this paucity and investigate the experiences of women who had experienced FGM and the resultant psychological effects. The specific focus was to also understand the psychological impact of physical health complications and women's resilience within their cultural context. The research addressed the following questions:

- What are survivors' experiences of Female Genital Mutilation?
- What are survivor's understandings of the impact of their experiences?
- How do survivor's deal with the impact of their experiences?

2.2. Methodology

2.2.1. Research design

The research adopted a grounded theory qualitative methodology aimed at providing in-depth, existential accounts of women's views and experiences of the psychological impact of FGM. Lee (1993) identifies three features of sensitive research; (a) issues that are private, stressful or sacred, (b) issues that if revealed might cause stigmatisation or fear, and (c) research where subjects are related to a political threat. As the topic of FGM is sensitive in all of these domains, a qualitative approach for carrying out sensitive research was considered the most appropriate. This enabled the context and cultural norms within which the research took place to be highlighted, as well allowing for the development of a theoretical model arising from women's own views and experiences.

2.2.2. Researcher's position

The lead researcher took a social constructionist and critical realist epistemological position. In line with this, a reflexive stance towards the research process and analysis was used where the researcher acknowledged the role of their own presuppositions and interpreted data contextually within time, place, culture, and situation (Bryant & Charmaz, 2007). The lead researcher managed her own position reflexively through regular supervision and completing a research diary.

2.2.3. Sampling design

A non-probability convenience sampling frame based on snowballing was utilised. This strategy was considered appropriate within the context of a grounded theory method due to the concealed nature of FGM (Faugier & Sargeant, 1997; Oktay, 2012). Consequential to the continual interplay between data collection and data analysis when using grounded theory, as the research progressed, a theoretical sampling strategy was increasingly used to allow selection of further participants to explore and understand ideas presented by participants within a theoretical construct (Gordon-Finlayson, 2010).

2.2.4. Participants

Participants inclusion and exclusion criteria are outlined in Table 2.2

Table 2.2: Participant inclusion and exclusion criteria

| Inclusion criteria | Exclusion criteria |
|---|---|
| 1. Participants over the age of 18 years | 1. Those who felt their safety may be compromised by taking part |
| 2. Participants residing in the UK | 2. Those who felt their mental health may be compromised by taking part |
| 3. Participants able to provide informed consent | |
| 4. Participants able to identify themselves as having experienced FGM | |

Twenty participants were recruited including women from Somalia (n=10), Kenya (n=2), South Africa (n=6), and Gambia (n=2). Eight women identified themselves as being Catholic and twelve women identified themselves as being Muslim. The mean age of participants was 38 years (SD=6.5, range=25-51). The average length of time in the UK was 12.5 years. Participant demographics are listed in Table 2.3. To ensure anonymity, only pseudonyms and age ranges are given.

Table 2.3: Participant information

| Pseudonym | Age range (years) | Country of Origin | Religion | Length of time in UK (years) | Age of having FGM (years) | Type of FGM | Marital status | No. of children | Occupation |
|------------------|--------------------------|--------------------------|-----------------|-------------------------------------|----------------------------------|--------------------|-----------------------|------------------------|-------------------|
| Amina | 51-60 | Somalia | Muslim | 17 | 7 | 2 | Married | 3 | Housewife |
| Jamina | 31-40 | Somalia | Muslim | 20 | 7 | 3 | Married | 4 | Housewife |
| Faridah | 41-50 | Kenya | Muslim | 15 | 5 | 3 | Divorced | 0 | Psychotherapist |
| Larissa | 41-50 | Somalia | Muslim | 20 | 7 | 3 | Married | 5 | Charity worker |
| Saleema | 41-50 | Somalia | Muslim | 20 | 5 | 3 | Married | 9 | Housewife |
| Ebony | 31-40 | Somalia | Muslim | 30 | 3 | 3 | Married | 4 | Housewife |
| Zahara | 31-40 | Somalia | Muslim | 12 | 8 | 3 | Married | 6 | Housewife |
| Alia | 41-50 | Somalia | Muslim | 25 | 4 | 3 | Married | 9 | Housewife |
| Sabina | 31-40 | Somalia | Muslim | 7 | 7 | 3 | Married | 5 | Housewife |
| Fabia | 31-40 | Somalia | Muslim | 14 | 7 | 3 | Married | 5 | Housewife |
| Halina | 31-40 | Somalia | Muslim | 1 | 8 | 3 | Married | 3 | Housewife |
| Vada | 41-50 | South Africa | Catholic | 17 | 8 | 4 | Married | 3 | Charity work |
| Samina | 31-40 | Gambia | Muslim | 6 | 7 | 2 | Married | 3 | Support worker |
| Asha | 31-40 | South Africa | Catholic | 4 | 5 | 3 | Married | 4 | Cleaner |
| Patience | 21-30 | South Africa | Catholic | 6 | 7 | 4 | Married | 5 | Charity worker |
| Saskia | 41-50 | South Africa | Catholic | 9 | 7 | 4 | Married | 4 | Housewife |
| Filomena | 41-50 | Kenya | Catholic | 17 | 6 | 3 | Married | 1 | Housewife |
| Neema | 31-40 | South Africa | Catholic | 8 | 5 | 3 | Married | 6 | Housewife |
| Keisha | 21-30 | Gambia | Catholic | 3 | 6 | 4 | Married | 2 | Housewife |
| Wilo | 21-30 | South Africa | Catholic | 5 | 7 | 3 | Married | 1 | Nurse |

2.2.5. Procedure

2.2.5.1. Ethical considerations

The research was designed and conducted in accordance with the British Psychological Society (2010) ethical guidelines and full ethical approval was granted from Coventry University Ethics Committee (Appendix E). Due to the sensitive nature of the research, measures were taken to ensure ethical recruitment of participants. The research was advertised with permission of relevant gatekeepers and participants were able to contact the researcher. Measures were taken to safeguard the participants from harm. The researcher regularly checked that women were able to continue during the interview and a detailed debriefing was given. Where consent was obtained, the researcher made a follow-up call to the participant at a pre-arranged time after the interview to ensure they were not experiencing distress.

2.2.5.2. Materials

In accordance with grounded theory methodology (Strauss & Corbin, 1998), a semi-structured interview schedule was developed (Appendix J). In conjunction with the highlighted gaps in the existing literature, to aid the development of the schedule, consultations were held with experts in the field of FGM as well as survivors who volunteered their expertise based on their personal experiences. The first part of the interview sought to obtain demographic information about the participant's age, type of FGM, country of origin and religion. The second part sought to understand the impact of participant's experience of FGM and included questions about their recollections of having FGM and how this impacted their lives. Questions were also asked about the factors that helped women cope with their experiences.

2.2.5.3. Recruitment

Participants were recruited through a number of UK refugee centres and non-government organisations (NGO) working with survivors of FGM. The research was advertised using posters (Appendix F) and leaflets (Appendix G). Potential participants were provided with an information sheet (Appendix H) and permitted to view the interview schedule (Appendix J) in order to aid their decision-making regarding their participation. Women who expressed an interest either contacted the researcher, or left their contact details with a professional at the NGO for the researcher to establish contact and an interview date was arranged following a response to any questions asked. In accordance with grounded theory analysis; participants were recruited until theoretical saturation was reached (Strauss & Corbin, 1998). Theoretical saturation was attained following analysis of the twentieth interview when the data was no longer generating new concepts and the properties of the categories identified were considered sufficiently dense (Glaser & Strauss, 1967). Homogeneity of participants (Creswell, 1998) was achieved based on recruiting women who had experienced FGM and who currently resided in the UK.

2.2.5.4. Interview procedure

Prior to taking part in the interview, participants were provided with an information sheet (Appendix H). Time was allowed to provide the opportunity for participants to ask questions relevant to their participation and for any concerns to be explored. Written consent was then obtained (Appendix I). All interviews were audio-recorded and ranged from 25 to 127 minutes in length. Upon completion of each interview, a verbal debriefing was provided by the researcher to ensure participants were not distressed, and to signpost them to support services if required.

2.2.5.5. Method of data analysis

Interviews were transcribed verbatim and all identifiable information was removed. Each participant was allocated a pseudonym allowing only the researcher to identify the data with the participant.

In line with grounded theory procedure (Strauss & Corbin, 1998), data analysis and data collection ran concurrently. To facilitate data management and exploration, the computer programme Atlas-Ti Version 5.2 was utilised (Appendix K). Through the process of grounded theory analysis, 373 open codes and 38 axial codes were identified. When no further meanings could be attained and data saturation was reached, selective coding identified nine core categories (Appendix L) thereby leading to the development of a model. Table 2.4 denotes the main stages involved in the analysis.

Table 2.4: **Stages of grounded theory analysis** (Strauss & Corbin, 1998)

| Stage of Analysis | Actions Taken |
|-------------------|--|
| Open coding | Data was examined line- by- line in order to segment the data into similar groupings. This formed preliminary categories and subcategories of information about the phenomenon being examined. (Appendix L) |
| Axial coding | Categories and subcategories previously identified were grouped together into themes identifying central phenomenon's around which differences in dimensions existed. (Appendix L) |
| Conceptual coding | Previously identified themes and categories were integrated, defined, and developed into a coherent theory of the phenomenon of the study. Constant comparison between categories allowed confirmation of whether the data supported emerging categories while simultaneously building and substantiating categories by defining their properties and dimensions. It further identified if supplementary or differing data needed to be obtained through purposeful sampling. (Appendix L) |

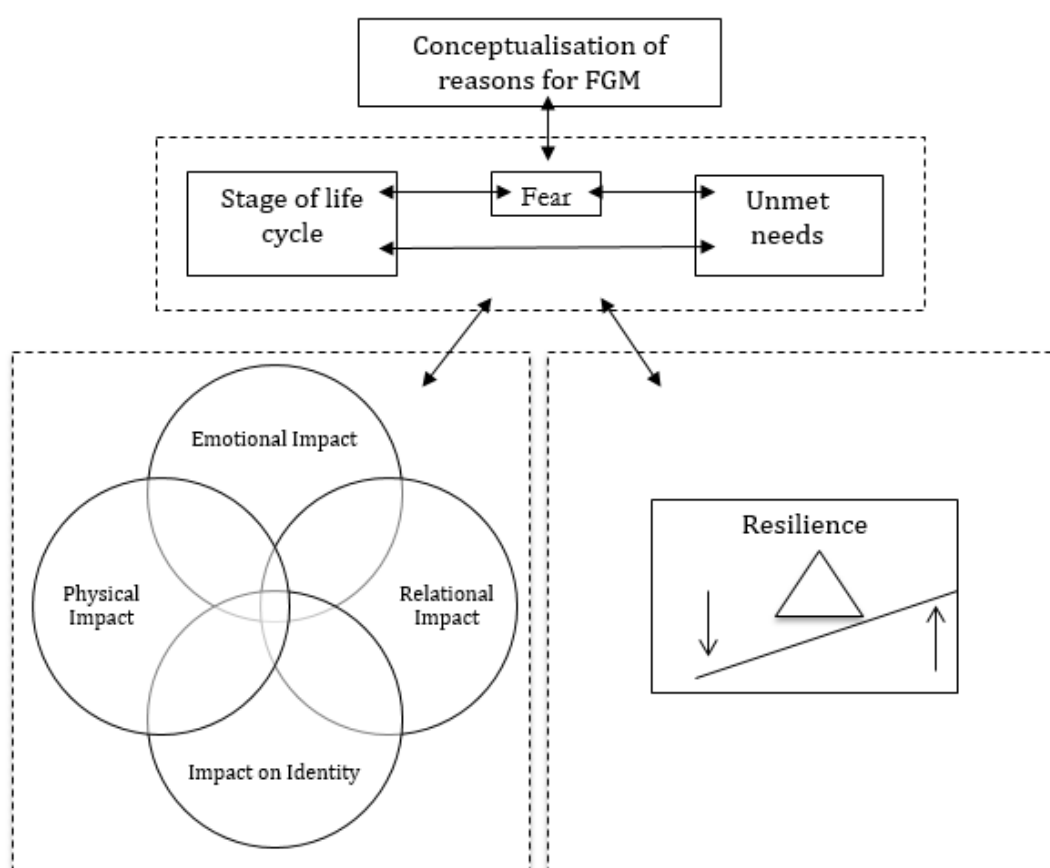
2.2.5.6. Credibility of the study

To ensure the credibility of the research (Mays & Pope, 2000), the researcher's supervisory team checked the initial open coding and emergent axial and conceptual codes. Where prior consent had been granted, participants were invited to validate the emergent themes of their transcript. No changes were made in response to these checks due to agreement on the concepts extracted.

2.3. Results

A pictorial representation of the theoretical model was created (see Figure 2.1). The purpose of the visual depiction was to facilitate comprehension of the research findings and the relationship between the core categories.

Figure 2.1: Model depicting the Psychological Impact of FGM



2.3.1. Model describing the psychological impact of FGM on women participants

Women participants related culture, religion, the role of men, lack of education, female identity and deception as major factors influencing their conceptualisation of the reasons for FGM. Their experiences of FGM, as well as being influenced by their conceptualisations of the practice, led to effects on their emotional life, relationships, identity, and physical body. The fear that women described resulting from FGM affected

their ability to enhance their resilience. All of the core categories of emotional, relational, identity, and physical impact, as well as resilience, were also influenced by key stages of womanhood including menstruation, marriage and childbirth and compounded by their ongoing unmet needs and the lack of meaningful, sensitive, and effective service responses.

Whilst the above relationships are emphasised, the findings are presented below through discussion of each category and axial code. Due to the limited scope of this report, it is not possible to discuss in detail all of the axial codes, thus additional verbatim quotes pertaining to these can be found in Appendix M.

2.3.2. Conceptualisation of reasons for FGM

This category included the following axial codes: lack of knowledge, religion, the role of men, cultural pressure, female identity, and deception as factors that allowed and encouraged the practice of FGM within the broader framework of FGM being viewed in society as a social norm.

2.3.2.1. Lack of knowledge

Women reported a lack of knowledge as being one of the reasons for the practice of FGM. As Zahara (Lines 274-176) described:

If they educated, knew about the pain after that then they wouldn't do it because they didn't have any knowledge...culturally if they were educated they might have said no don't have it.

Women interviewed considered that FGM was carried out due to the ignorance of society regarding its consequences.

2.3.2.2. Female identity

Women conceptualised the practice of FGM as being necessary due to their identity as female, for instance Faridah (Lines 230-231) narrated:

The whole reality of just being a woman, what I had to go through just for the fact I am a woman.

Women participants explained that without FGM women were thought not to have any value. Having FGM was considered by women I spoke to as a symbol of the transition from childhood to womanhood.

2.3.2.3. Religion

Many women explained that religion was 'given' as a reason for the practise of FGM by their family. This was consistent across women from both Catholic and Muslim religions. For instance, Neema (Lines 66-67), a Catholic stated;

When I was a small girl, the reason they gave me for FGM is religion. They told me not to have FGM would be to go against religion. I was brought up Catholic, why would I question my religion?

This was also commented on by Fabia (Lines 150-151), a Muslim, who explained that:

It [FGM] was up to religion. We were brought up to believe that FGM is in the Holy Koran and we have to do it to please Allah.

However, all of the women interviewed identified that they later realised FGM had ‘nothing to do with religion’. This led some women to believe that religion was used as a ‘scapegoat’ by practising communities to try and justify the practice of FGM.

2.3.2.4. Culture

Culture was also considered by participants as a reason for FGM being carried out. For instance, Zahara (Lines 261-263) explained:

I’m angry because of the culture, they believe you have to have it, so I don’t blame anyone but I do blame culture when I hear it, it makes me angry, why do they do these things to me.

However, perceiving it as culture did not justify the practice to women and Faridah (Line 298) described it as being: “...like someone coming and cutting your finger because of culture”.

2.3.2.5. Role of men

Women understood the role of men to be a core social pressure underpinning the practice of FGM as Fabia (Lines 250-251) explained:

Back home I think the reason they were doing it is for the man's sake, people were believing that without FGM the girl wouldn't be a virgin and couldn't get married as the man would reject her.

Samina (Lines 344-345) explained that girls were told having had FGM made them:

... purified, we are clean...because that's what they normally tell us, they say if you are not cut it means you're not marriageable.

2.3.2.6. Deception

Women participants further understood the practice of FGM as being the result of deception. They explained that in many countries where FGM was carried out, parental consent was not required. Women related they were also scared to take their children back to their home countries for fear that someone may carry out FGM on them without their permission.

2.3.3. Impact on identity

Women reported FGM had impacted upon their identity in multiple ways. Within this conceptual code, there were four axial codes including feeling different, identity as a woman, loss of childhood identity, and unknown identity.

2.3.3.1. Feeling different

Women expressed that they often felt as though they were 'not normal', or different from women who have not had FGM, as Patience (Lines 92-93) described:

The problem is I am not like people who have not had FGM, I'm not the same, I'm not normal like them.

Women's feelings of difference were accentuated by living in the UK where FGM is not considered 'the norm' and voiced that they tended to be judged harshly by society.

2.3.3.2. Identity as a woman

Women stated that FGM impacted upon their identity as a woman. For instance, Saskia (Lines 80-81) expressed:

I'm a woman, only I'm not am I? They took away all the parts that made me a woman.

The axial code 'identity as a woman' was deeply connected with the physical impact of FGM, particularly in relation to the effect on sexual relationships and intimacy.

2.3.3.3. Loss of childhood identity

Loss of identity as a child was highlighted by women I spoke to as being a key impact as Samina (Lines 1600-1601) related:

From the minute I had FGM my childhood was gone, no more playing, no more laughing, in culture's eyes I was a woman.

The sense of lost childhood identity women described was enhanced when they had their own children and witnessed how their childhood could have been without FGM. Many

of the women participants related that once they had FGM they were no longer allowed to 'run around' in case they tore open the stitching. They also described this as having an impact on their value as a woman in society.

2.3.3.4. Unknown identity

Some of the women interviewed expressed loss of an unknown identity as described by Vada (Lines 407-410):

I know what happened changed me. I will never know if I was going to be the person I am or the child I was...she's taken that away from me. I will never know that; I will never know how it's like not to have someone...inserting fingers inside of you.

Many women felt that FGM prevented them from becoming the person they could have been if they had not had it.

2.3.4. Emotional impact

Four axial codes were identified within this category including anger, remembering, shame, and avoidance. The emotional impact identified by women were inter-related and interlinked with an impact on identity, physical health, and relationships.

2.3.4.1. Anger

Many of the women's narratives described feelings of anger, which impacted on different areas of their lives. Some women interviewed expressed general anger when thinking about their experiences of FGM as Saskia (Line 68) stated:

I don't even have the words for how angry I feel when I think about the FGM.

Vada (Line 464) expressed the intensity of her anger regarding having been made to have FGM stating:

I understand why people take a gun...and shoot people, it's not an excuse but sometimes I feel so angry about the impact of FGM.

Other participants expressed feeling anger towards the perceived misrepresentation of religion as a reason to carry out FGM. For example, Filomena (Lines 42-43) asserted:

It makes me angry to speak about. People say it's culture, it's tradition, it's nothing and neither. It's not about religion or nothing, it's just women hating women and hurting them.

As expressed by Patience (Lines 73-74), particularly apparent was the anger women felt towards their mother:

I often get angry and think about how much I hate my mother, 'stupid selfish b***h' who let me go through this.

Women's anger towards their mothers related not only to them allowing the FGM, but also that their mothers' did not stay with them when being 'cut'. As Faridah (Lines 82-83) described:

I feel really angry really really angry that she went out of the room [to] save herself but didn't think of me.

Furthermore, women expressed anger at not being able to enjoy aspects of their lives including sexual intimacy because of having had FGM.

2.3.4.2. Remembering FGM

Women interviewed accentuated a number of different situations, sounds, and smells that elicited vivid recollections of FGM. Some women stated that having sexual intercourse reminded them of the procedure. For example, Keisha (Lines 47-48) said:

I didn't want to have to have sex ...I thought he was trying to cut me like she did ... lots of times I kick him and scream!

Some women interviewed reported recalling their experiences of FGM in the form of nightmares, whilst for other women, remembering it led them to relive their experience as Keisha (Line 93) expressed:

His fingers[husband] in me makes me want to be sick as in front of my face I see the 'cutter' and not my husband.

2.3.4.3. Shame

Women identified feelings of shame due to their status of being an FGM survivor. These feelings affected different areas of the women's lives as Saskia (Lines 72-74) explained:

When I had the baby all I felt is that they are going to do the FGM to me again. They hurt me so much. The doctor, the nurse, they never seen it before, and made me feel like such a fool, like some kind of crazy person. They just laugh and say some cultures are silly. I felt this big, and thought I wish I was dead.

Women further explained that their daughters' had also been made to feel ashamed to come from a community that practiced FGM.

2.3.4.4. Avoidance

For some of the women interviewed, the emotions associated with the causes and impact of FGM were experienced as intolerable. In order to cope, some women described dissociating to manage the emotional impact. For example, Neema (Line 46) described dissociating to cope with the fear she experienced when having sexual intercourse: "...to have sex I have to go into a dream world and pretend I'm somewhere else until it over".

Other women described somatisation, in which their emotional pain was expressed as physical pain, as Halina (Lines 128-129) explained:

I used to be so scared of having sex with the man that I would have headaches and feel sick every night worrying that I would have to have sex.

2.3.5. Relational impact

A dominant category was the negative impact that having FGM had on women's relationships with others. Four axial codes were contained within this including attachment with child, marital relationship, relationship with mother, and trust. As

depicted in Figure 2.1, the relational impact was entwined with the emotional, identity, and physical impact.

2.3.5.1. Attachment with child

Women described the impact of their FGM experience on their attachment with their child. Women related how due to the elongated physical pain due to complications with childbirth, they were unable to care for their child as they would have liked, and Neema (Lines 58-60) expressed:

I couldn't really walk or move for a few weeks after they cut me, so it took long time for me to care about the baby. My sister looked after the baby until I could walk and the baby never really remembered I was her mother.

Other women described feeling resentful towards their child due to the physical pain they experienced during childbirth.

2.3.5.2. Marital relationship

Women reported that having FGM heavily impacted on their relationship with their romantic partners as described by Vada (Line 268): "...it's something that follows you, it follows you in your relationship and in your marriage". Also inter-related with the expressed physical and emotional impact of FGM, women narrated it affected sexual and emotional intimacy with their husband as Wilo (Lines 35-37) explained:

It creates a wall through us, sex is a big part of a relationship and FGM take that away from me and my husband

2.3.5.3. Relationship with mother

Women described FGM as having a significant impact on the relationship with their mother and Faridah (Lines 86-88) explained that:

A lot of things came out of having had FGM but the most damage FGM has done to me was damaged my relationship with my mum. She was a mother.

Whilst some of the women described FGM as having broken their mother-daughter relationship, others described a more conflicted relationship where they felt an obligation towards their mother, however having FGM affected this bond as Keshia (Line 42) stated:

I have to love her because she is my mother, but if you ask me honestly... I say I never loved her the same again after the FGM.

For many women, underpinning the impact of FGM on their relationship with their mother was the feeling of being let down and unprotected as for many women as their mothers were absent at the time they were being ‘cut’

2.3.5.4. Trust

Women interviewed revealed that having FGM impacted on their ability to trust others, particularly other women, Saskia (Line 81) said; “...I will ever trust another woman again as long as I live”. As a result, this prevented some of the women from making friends, “...I don’t trust particularly the black lady, I can’t even have any friends as I don’t trust people” (Patience, Line 79-80).

2.3.6. Physical impact

This category encapsulated three axial codes including pain, pregnancy and childbirth, and health complications. The physical effects were considerably compounded by women's unmet needs due to limited service provision and responses.

2.3.6.1. Pain

Many of the women interviewed reported experiencing continual pain everyday due to FGM. As Filomena (Line 29) asserted: "Stop ha! [Physical] pain with FGM never stop, it stays your whole life". The pain experienced was intensified by woman's stage of life.

2.3.6.2. Pregnancy and childbirth

Due to having FGM, many women reported difficulties delivering their children, with them often having to be 're-cut' to facilitate delivery. Five women interviewed had tragically lost children during childbirth due to the physical health complications of FGM as Filomena (Lines 37-39) described:

I went into the labour and they did not realise I was stitched and when they realised it was too late and...and [pause]...they called the doctor but by the time he got there she was blue. She had died; they couldn't get her out in time. She was perfect and FGM took her away from me.

The physical impact of FGM on childbirth was related to the impact of FGM on identity.

2.3.6.3. Health complications

Lifelong health complications were described by women participants as a result of FGM and Saleema (Line 131) stated: “...because of FGM I have urine infections all the time”.

Women described health complications as being more pertinent during particular stages of their lives. For example, Samina (Line 467) reported considerable pain related to menstruation; “...you have difficulties in having menstruation, you have some pains and also it doesn’t come, like, normally. Like the way it’s supposed to”.

2.3.7. Unmet needs

Unmet needs due to limited service provision was identified by women as exacerbating the other effects of FGM. Within this category there were four axial codes including lack of professional knowledge, need for a special service, need for validation, and talking therapy.

2.3.7.1. Lack of professional knowledge

Women emphasised that the lack of professional knowledge regarding FGM had a negative impact on their experiences within services as Larissa (Lines 607-610) stated:

Woman professionals say ‘those people [FGM survivors] don’t deserve to have children, they are barbaric’. Ignorance and this is the worst that we hear from professionals...they ignorant.

Women expressed how the lack of professional knowledge led them to feel stigmatised by services as Larissa (Lines 576-577) explained:

My biggest psychological impact I have of FGM is through our health service, it's all about these people look at me differently.

Women identified that they felt there was a significant need for increased staff training and awareness.

2.3.7.2. Need for specialist services

Women participants considered that there was significant need for specialist services to support women survivors of FGM and Saskia (Lines 110-111) stated:

I think we need special services where people are well trained in working with FGM so that women feel safe and they are understood.

Due to complexities with sexual intercourse, menstruation, and giving birth, women articulated that they felt there was a need for clinics that would reverse or 'open-up' the FGM. Women further stated that they felt there was a particular need for greater support following childbirth, in light of the possible complications, which having FGM could cause.

2.3.7.3. Talking therapy

Women expressed that increased psychological support and counselling was needed within health services, and Wilo (Line 68) stated:

...someone to help me understand it. Every day it goes round in my head and if someone could get me to a place where it makes sense.

Whilst some women participants preferred the idea of having individual therapy, others felt therapy would be safer within a group setting. The need for increased psychological services was considered by women to be most needed within maternity services.

2.3.7.4. Need for validation

In line with the identified need for specialist services, and psychological support, women emphasised that the most important element of any service was the professional's validation of their experiences and Faridah (Lines 359-560) expressed how this was her central memory of her engagement with services:

It was just the way she dealt with the whole thing, she was deeply caring and she was really deeply moved. She was just a doctor to examine me and then I think it was just how sensitive she was with the whole thing just stuck in my memory.

2.3.8. Resilience

Women's experiences of FGM impacted on their resilience. There were four axial codes that influenced women's ability to build resilience including; conceptualisation of their experience as 'lucky', a sense of duty, empowerment, and resistance.

2.3.8.1. Conceptualisation of one's own experience as lucky

Despite describing numerous effects of FGM on their lives, many women considered themselves as lucky in comparison to others as Faridah (Lines 269-270) described:

I hear a lot of survivor's stories and sometimes when I hear the amount of physical pain they have gone through...thank God I'm lucky that the least of my pain is the physical pain.

Women I spoke to described enhancing their resilience through feeling they were lucky.

2.3.8.2. Sense of duty

Women described a sense of duty to campaign against FGM, which they also felt enhanced their resilience as Samina (Line 1130) described:

A day hasn't passed when FGM hasn't come into my mind and I take it upon myself as a big duty to carry out campaigns.

Women I spoke to who did not describe themselves as being involved in campaigns against FGM, expressed a duty to advise others against it.

2.3.8.3. Empowerment

Women voiced a sense of empowerment that facilitated their resilience, for example, Faridah (Lines 276-277) said:

Sometimes something horrible happens to us and we think why is this happening to me but there is there some sort of a benefit in it some sort of a lesson in it some sort of a growth in it.

Some women described a feeling of success out of the empowerment their experience of FGM led them to have.

2.3.8.4. Resistance

Women narrated how their experience had helped them build resilience to resist the practice of FGM as Filomena (Line 53) said: “I have to stop other people doing it to their children. My soul will not rest easy until it ended”. All the women interviewed expressed that they would not let their daughters have FGM, often enhanced by a sense of not wanting others, particularly their daughters’ to go through what they went through.

2.3.9. Stage of life

Analysis of the interviews revealed the impact of FGM was most pertinent at certain stages of women survivor’s lives. Four axial codes were identified within this category including death of own mother, menstruation, sexual relationship/marriage, and childbirth and becoming a mother.

2.3.9.1. Death of own mother

Women expressed that the impact of FGM was greatly influenced by the passing away of their mother as it filled women with a sense of obligation to forgive. As described by Faridah (Line 101): “...it's a forgiveness that comes with the fact that she has passed away”. Often women described conflicting feelings towards their mother after her death, inclusive of guilt, anger, and sadness.

2.3.9.2. Menstruation

Women described menstruation as a regular reminder of FGM and some women of Muslim religion expressed how this impacted on their ability to manage the impact of FGM due to not being able to pray. Faridah said (Lines 177-180):

Because I'm not praying and I don't have that sort of spiritual awakening or consciousness I sink into a deep depression and the connection with my femininity and all of that brings back memories...that puts me in a really down place.

All women stated that menstruation reminded them of FGM due to the physical health complications, which made it painful.

2.3.9.3. Sexual relationship/marriage

Women participants expressed the impact of FGM was made worse the first time they had a sexual relationship when they were married. Due to the complications of intercourse having had FGM, it was at this point that many women reported to have questioned their identity as a woman.

2.3.9.4. Childbirth/becoming a mother

Women articulated that once they had their own children, the negative impact of FGM was enhanced and Wilo (Lines 46-47) expressed that “...now I have a child I don’t know how a mother could ever hurt her child”. This was often accompanied by increasing women’s resilience.

2.3.10. Fear

Fear was a category, which influenced the impact of FGM, as well as women's ability to enhance their resilience. This encapsulated two axial codes including womanhood and ability to cope.

2.3.10.1. Womanhood

Women voiced fear relating to aspects of womanhood particularly their sexual relationships, which was entwined with a fear of rejection, as Wilo (Line 34) expressed:

I live in fear that my husband will leave me and find a lady who wants sex or who is not pained by it.

Further feelings of fear concerning womanhood related to women's fear of having their menstrual cycle, as well as childbirth. Fear of menstruation and childbirth was intensified if women had family or friends who had experienced complications with childbirth consequential to FGM. Some women I spoke to expressed how the feeling of fear led them to experience physical symptoms as Jamina (Line 67) explained; "...I had a lot of headaches as well because of feeling so scared".

2.3.10.2. Ability to cope

Women reported that fear affected their ability to cope with the impact of FGM by intensifying the other effects. For example, Neema (Lines 62-63) stated:

Sometimes I am so scared that I think I cannot cope. I think that I can cope and then I get scared about something and I remember that FGM make me weak.

At other times fear enhanced women's ability to cope as described by Asha (Lines 161-162):

When I think of FGM I feel frightened to be honest, but it's a good frightened as it reminds me of what I went through and makes me strong.

2.4. Discussion of findings

The present study conducted in-depth interviews to explore women's experiences of FGM, the impact of their experiences, and how they coped with this. A model was developed to show that FGM survivors conceptualised various factors as being the reasons for the practice of FGM including culture, religion, the role of men, lack of education, female identity and deception. This context was perceived by women to be extremely important and influenced the emotional, relational, identity, and physical impact of their experiences, as well as their ability to enhance their resilience. All of these factors were influenced by fear and key stages of womanhood. Women's unmet needs and the lack of effective service responses to meet these increased the impact of their experiences.

This study advances understandings regarding the complex relationship between religion and FGM. Religion was a main reason given to the women by their parents for the practice of FGM. Whilst this is supported by other research (Keeder, 2002), and the association between FGM and the Muslim faiths is well documented (Mohammed, Hassan, & Eyada,

2015), few research studies have looked at FGM within the context of Catholicism. Women in the current research reported poor understanding within different cultures and societies of the role of religion in perpetuating the practice of FGM. Women of both Catholic and Muslim faiths considered religion to be a 'scapegoat' for FGM and being educated had taught them that FGM was not advocated in either religions' holy texts. Whilst education programs have been introduced within Muslim communities, the role of Catholicism has largely been neglected.

Despite the prevailing view of the role of religion in facilitating FGM, women themselves maintained strong religious associations, and found times when they were unable to pray, such as during menstruation, a particular challenge to their ability to cope with the impact of FGM. This finding builds upon research (Bryant-Davis & Wong, 2013) that showed the power of spirituality in coping with traumatic events. The present research highlights the possibility of religious groups to advocate and educate against this practice.

The present study further advanced existing knowledge by exploring the complex and multifaceted role of patriarchy relating to the psychological impact of FGM. Women viewed FGM as inherent to their identity as a woman and expressed that without FGM they would not be marriageable as they were considered 'impure' by their community. This was supported by previous research (Ashimi & Amole, 2015). However, the current research also revealed how the role of patriarchy also influenced the impact of FGM, particularly in relation to women's identity.

Due to the physical impact of FGM, many women felt unable to please their male partner sexually and consequently avoided sexual intimacy. Whilst these physical health impacts are acknowledged in other literature (Elnashar & Abdelhady, 2007; Lundberg &

Gerezgiher, 2006), the present research argues that as patriarchal values led women to place to the needs of their male partners above their own needs, participants construed their ability to pleasure men sexually as integral to their identity as a woman. Being unable to do so posed a challenge to their identities as women. This sometimes led to emotional conflict depending on how supportive women's husbands were. This was broadly consistent with other research into gender-based violence (Courtois, 1979). The current research supported the view that the practice of FGM and its relationship to male sexual pleasure still needs to be challenged. In addition, the reality of women's experiences was that it results in severe gynecological damage and psychological distress and therefore there are human rights implications arising from women's resulting health needs.

Patriarchal subordination of women was also uniquely emphasised in this research by women's conceptualisation of deception as a pertinent reason for the practice of FGM. As consent was not needed by a child's parent to have FGM, women trying to resist the practice were placed in a disempowered position. The socialisation of women to adhere to behaviors consistent with male desire led women to self-enforce patriarchal values. This often led participants in the current study to blame and become distrustful of other women, thereby depleted women's ability to act in a unanimous way against patriarchy in society.

The qualitative approach used by the current study also allowed unique understanding of how the interaction between the physical and relational impact of FGM related to the destruction and re-construction of a woman's multiple identities; including being a woman, a mother, and a partner. Women's construction of what it means to be a woman is intrinsically linked to notions of womanhood in Africa where a women's worth is connected to her ability to have children (Bourke, 2013). Due to the physical health

impact of FGM, some of the women had lost their unborn babies due to complications giving birth. This obliterated women's identity in all three aforementioned domains. Losing a child in African culture has been documented as a 'double blow', due to the stigmatisation and rejection women experience as well as the loss (Layne, 2003).

This study is the first to demonstrate the significant impact on the attachment relationship between mothers who had FGM and their child. By developing a greater understanding of the relationship between identity, physical health, and the relational impact of FGM, the present research highlighted novel information that due to the physical health complications of giving birth, many women experienced separation from their child, or the inability to adequately attend to their child needs. Women interviewed considered this to impact on their bond with their child. Whilst no other research has addressed this specific finding, it is well documented that traumatic childbirth and physical health complications can lead to difficulties in forming a secure mother-child attachment (Allen, 1998; Bailham & Joseph, 2003).

Based on these findings, it is evident that the needs of FGM survivors are neglected after childbirth. This echoed research by Liebling et al., (2012) who found support after childbirth for rape survivors in Congo also tended to be limited to the detriment of survivors' post-natal health, as well as the welfare of their children. These principles can be applied to the current research findings that argue for the pressing need to improve post-natal healthcare of women who have had FGM.

To reconstruct their identities as a woman and as a partner, many of the survivors believed there could be service provision to allow them to have the FGM reversed. The current research emphasised that whilst there is a large body of research into the physical impact

of FGM, there remains a lack of understanding of how this can be managed more effectively within health care services. Furthermore, the research highlights the importance and understanding somatisation in response to the emotional distress the women experience. Failure of service providers to recognize somatisation affects women's ability to access appropriate services, thus, lack of understanding and knowledge by health care professionals contributes to the unmet needs of the women. Women also described their unmet needs exacerbating the emotional, identity, physical, and relational impact of FGM, as well as women's resilience.

Findings showed women perceived UK professionals to have limited knowledge and skills related to FGM, as well as stigmatising attitudes. In conjunction with the shame which was expressed by women following FGM within the study, these factors act as significant barriers in being able to access appropriate and sensitive support services. This is consistent with wider research into the impact of sexual and gender-based violence against women (Henttonen et al., 2008)

The current study advances understandings of how different life stages can pose further challenges to the mother-daughter relationship for women survivors of FGM. The death of a mother was shown to increase conflictual feelings regarding the mother-daughter relationship. Death of those involved in abuse, has been linked with survivor's experiences of grief towards the loss of closure, with the abuser's death signifying a lost opportunity to confront the perpetrator (Bass & Davis, 1998). However, although women in the current study, tended to sometimes blame women for having FGM, this has to be understood within the context of a broader patriarchal society, with cultural and societal pressures exerted to maintain this practice.

The present study highlighted novel findings relating to facets that enhanced women's ability to build resilience as a central coping mechanism against the impact of FGM. Analysis of the data showed luck, sense of duty, empowerment, and resistance as factors that aided women's resilience. The importance of enhancing resilience has been emphasised across wider research into gender-based violence in which survivors are frequently disempowered and viewed as victims (Mahoney, 1994; Boyden, 2000; Liebling-Kalifani, 2009). However, the findings of the current research uniquely advance understanding into facets that enhance resilience as well as generating understanding regarding how resilience can be influenced by fear, different stages of women's lives, and unmet needs. The impact of unmet needs on women's resilience, emphasises the need for increased service provision.

2.4.1. Implications for service provision, policy and practice

Important policy implications related to children being able to have FGM without their parents' consent. This indicated a need for increased regulation about parental and children's rights in practising countries. Within the UK it further calls for increased scrutiny over children being taken out of the country without parental consent (Female Genital Mutilation Act, 2003).

Whilst powerful structures including patriarchy and religion are hard to alter, there is the need for greater involvement of religious and cultural leaders in the education of communities about the relationship between religion and FGM. Such education programmes are currently being established in Egypt (United Nations Development Programme, 2015).

The current research highlighted a crucial training need within healthcare systems. Whilst at present it is acknowledged that healthcare professionals are required to ask about FGM as part of an assessment, there is no training or policy regarding appropriate support and service provision. It would be helpful to address this issue on a national and international level.

In view of the physical complications during childbirth, as well as the risk of losing a child, potential for reliving of FGM and the possible impact on the mother's ability to attach with her child, the current research argues that maternity services need to be improved to have a greater cultural understanding of the meanings of losing a child for women from African countries and the impact on their identity. Services could consider an increased integrated approach to working with survivors, which brings together physical and mental health services. Consistent with research by Liebling et al., (2012), in relation to women and girls who became pregnant from rape, the results of the present study accentuate the need to address the reproductive rights of women and girls who experience FGM. Additionally, reproductive health services and gynaecological care needs to be improved and it is the author's view that their health needs should be viewed as a human rights issue. Services should seek to obtain outcome measures, including qualitative information, regarding the effectiveness of their engagement with FGM survivors, including during pregnancy and childbirth.

Analysis of the interviews further emphasised a need for increased psychological support for survivors of FGM, both in the form of individual therapy, in addition to group therapy. The value of group therapy is noted in research by others (Wright et al. 2003) who argue that women's groups can contribute positively to the development of collective empowerment and positive growth in survivors of gender-based violence. Similarly, due to the evidenced relational difficulties that women experienced, increased provision for

individual and group counselling as well as family and couple psychological therapy could be provided as options for survivors.

The interviews highlighted that many women considered that there should be specialist clinics where the FGM procedure could be reversed. If these services were provided then clear assessment and specialist pathways need to be developed whereby their holistic needs, including psychological, social, legal and physical health needs, can be properly assessed and treated.

2.4.2. Limitations of the research and future directions

The current study highlighted important findings relevant to the group of women interviewed and these are considered within the context of limitations of the study. Firstly, the study focussed purely on women from African countries and therefore future research may seek to test the model developed, in different countries.

Due to the highlighted impact of childbirth and attachment, future research could also aim to ascertain a more in-depth understanding of the impact of FGM on attachment in order to better aid services in knowing how best to support affected women.

Women in the present study identified themselves as being of Muslim or Catholic faith, to further advance the understanding of the role of religion on the practice of FGM as well as in its prevention and service responses. The research could also seek to compare the influence of differing religions, perhaps through a further qualitative study involving faith-based communities and organisations (Tearfund, ongoing).

2.5 Conclusion

The current study developed a theoretical model showing the psychological impact of FGM based on women's experiences. The research unveiled complex and novel understanding of how patriarchy intensifies the physical, relational, emotional and identity impact of FGM. In particular, it has demonstrated the negative impact of FGM on the attachment between a mother and her child, as well as the impact on women's identity. It also showed how the impact of FGM can vary depending on the different stages of women's lives. Crucially, the study revealed resilience of survivors and emphasised the differing facets that enhanced this. The study held a number of key clinical and policy implications particularly in relation to UK maternity and reproductive and psychological health services.

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Chapter 3: Reflective Paper

**Title: Reflections on research regarding the psychological impact of
FGM: Consideration of theoretical and personal parallels**

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(See Appendix N for author guidelines)

3.1. Introduction and aims

This chapter presents a reflective account of the process of carrying out qualitative research on the psychological impact of female genital mutilation (FGM). A reflexive approach is positioned within feminist, critical, and poststructuralist paradigms that were considered essential to the qualitative research process.

Within a reflexive framework, the researcher is advised to consider their ‘presuppositions, choices, experiences, and actions during the research process’ (Mruck & Breuer, 2003, p.3), as well as their personal experiences, values, and positions of privilege in various hierarchies that have influenced their research interests (Harrison, MacGibbon, & Morton, 2001, p.325).

In view of this, a reflective narrative was kept throughout the research journey. Informal analysis of my researcher journal revealed a number of core areas of reflection, with many of the themes mirroring components of the theoretical model developed from the empirical data discussed in Chapter Two (Glover et al. unpublished). This chapter considers some of these parallels.

3.2. Recruitment

The recruitment of minority ethnic groups for research participation can prove challenging (Knight et al, 2004; Yancey et al, 2006) due, in part, to a lack of trust towards researchers’ intentions (Fisher & Ragsdale, 2005). This issue is often compounded by unsuitable recruitment methods that fail to consider both the context of the research population, and potential barriers to their participation (Yu, 2009).

In the current study, participant recruitment posed a particular challenge. Upon reflection, I considered several factors to have contributed to these difficulties including the role of legislation and the media, and perceptions of myself as the lead researcher.

Since the submission of my initial research proposal, the subject of FGM has been widely discussed in several forums including the media, and the legalities surrounding its practice were considerably tightened (Serious Crime Act, 2015; Female Genital Mutilation Act, 2003). The wide attention FGM received initially felt positive as it made the prospect of broaching recruitment appear easier. As a result, upon commencement of the recruitment process I believed the survivors might be grateful to hear from me. The reality of the situation was very different. Upon approaching gatekeepers of non-government organisations accessed by FGM survivors in London and the Midlands, I was regularly met with resistance, suspicion, or in many cases simply ignored. When given the opportunity, this was discussed with members of the practising community. They expressed that since FGMs' increased media presence, they had received an abundance of student requests to interview survivors. Some women reported negative experiences of being interviewed, when they were unclear where and how their information was being used. Women also reported that the increased attention had led them to feel stigmatised, with the tightened legislation around the practice increasing women's fear of being prosecuted for being part of a FGM practising community.

I also felt, perhaps controversially, that some gatekeepers were quite protective over survivors and hesitant to allow direct contact with them, restricting their informed choice about participation in my research. Instead they sometimes attempted to limit access, suggesting they carry out interviews and feed the data back to me. The dominance of the gatekeeper has been observed in other sensitive research within the sexual and gender-

based violence literature, with Hanley (2005) and Davison (2005) asserting that some gatekeepers overpowered and drowned the voices of others, thereby placing survivors in a disempowered position by not allowing them to make their own informed consent. Additionally, perhaps as a representation of the limited current services available to survivors of FGM, some organisations were only willing to allow contact with potential participants if they were able to attain a 'diagnosis' for women, as this would provide them with a means to increase their funding. This raised important awareness of the political and financial influences on this research process.

At this point during the recruitment I noted my own feelings of helplessness. Due to the reluctance of some gatekeepers to permit access to potential participants, I started to feel a distrust towards them. I reflected during the research process that my feelings of powerlessness and distrust, mirrored the feelings of my participants towards services. In this light, I wondered if my feelings were the result of counter-transference (Holmes, 2013) enhanced further by the frustration survivors have towards the lack of knowledge of health care providers in the United Kingdom.

It became clear at this stage that something would need to shift in the research team's approach to recruitment; however, I felt out of my depth and unsure how to progress the research forward. Due to the inherent distrust, the practising community appeared to hold towards researchers, it became evident that building trust and rapport with gatekeepers was essential. Furthermore, due to the excessive requests that women who had experienced FGM appeared to be receiving to take part in other research, I felt I needed to set my research apart from that of others and demonstrate my genuine passion for the topic.

When initially considering the complexities of this, I felt stuck as to how I might proceed and therefore sought support from my research team. Upon reflection, I believe my anxiety and desire to do justice to this research area led me to over-complicate how I could demonstrate my sincere interest. Although time-consuming, being invited to attend meetings by gatekeepers appeared to serve as an assurance of my character (Eide & Allan, 2005). It was therefore crucial to the recruitment process as it helped services develop trust and following several meetings I found myself overwhelmed with the number of women asking to participate.

The difficulties I experienced during recruitment emphasised the importance of considering my identity not only as a researcher, but as a professional trying to use research to promote and analyse women's own experiences of FGM, and to utilise this information to try to effect positive changes. This also helped me to be mindful that aligning trust and building relationships between myself and participants, and showing genuine personal interest in a research area, is essential for the effective completion of good research.

3.3. Position as 'an outsider'

Reflexive consideration of the researcher's position in comparison to their participants is an essential component of the qualitative research process (Koch & Harrington, 1998). Within this context, reflexivity involves researcher self-scrutiny of the ever-changing relationship between the researcher and the participant (Chiseri-Stater, 1996; Pillow, 2003).

Berger (2015) posits two differing positions that the researcher can assume; 'insider' or 'outsider'. When taking the 'outsider' position, the researcher assumes an unknowing role

where they have no prior connection with the study population. When taking the ‘insider’ position, the researcher holds prior experience and connections with the research participants.

When commencing the research, I was aware of my position as an outsider. While I had some experience and understanding of African culture having spent considerable time in South Africa, as well as working with women survivors of FGM, I was an outsider to the research participants. Being a British, middle class, white woman, I was very mindful of feminist narratives that criticise research with women (Devault, 1990) from ethnic minorities (Barrett & McIntosh, 1985; Carby, 1982; Shah, 2004) undertaken by outsiders, and their failure to accurately represent their experiences.

When considering my position as more of ‘an outsider’, I was concerned that I would come across to the participants as ignorant or naive. I was also aware of literature that argued white Western women can be perceived by non-Western women as ditsy, shallow, privileged, sexually available, and appearance focused (Conley, 2013). Prior to interviews with the women, I regularly felt anxious about how I came across to them.

I now wonder if my fear of judgement matched women’s own fears of being stigmatised and judged due being an FGM survivor, as reflected in the model developed from my empirical research.

Upon reflection, I consider my ‘outsider’ position to have been advantageous. Openly sharing with participants that I knew little about the practice of FGM, or about the differing cultural contexts and backgrounds of the women, allowed them to adopt an ‘expert’ position, thereby placing them in a more empowered standpoint. This helped

build trust with participants and lead to more detailed and comprehensive explanations of their experiences as participants spent time ensuring I understood what various terminology meant and that I appreciated their experiences within their own cultural and religious framework. This approach enabled women's underlying belief systems to emerge.

3.4. Navigating researcher-clinician roles

When carrying out interviews with survivors, I found myself experiencing some conflict between my clinical role as a Trainee Clinical Psychologist and the role of a researcher. This conflict has been widely acknowledged (Yanos & Ziedonis, 2006; Haverkamp, 2005) who emphasise the internal clash between a therapists' clinical obligation to act in the participants' best interests, contradicted by the researcher's mandate to pursue answers to research questions with appropriate rigor.

When carrying out the research, I immediately felt a sense of guilt that I was asking women to share their stories. Unlike a therapeutic relationship where I feel I am aiding individuals to make sense of their experiences and make progress, the dynamic of the research interviews often left me feeling guilt ridden. The nature of the research was very personal and intimate and the power imbalance between myself and the participants was difficult at times to manage both emotionally and practically. Although I was allowing them time to describe the impact of their experiences, it was a one-off research interview, very different to a therapy session where there is sufficient time to process experiences. To help manage this, I utilised peer support from fellow trainee clinical psychologists, as well as research supervision.

There were points throughout the research where I wondered if I was being unfair in putting the women I spoke with in this position. I was also aware at times that I was tempted to blur boundaries between researcher and therapist, often having to consciously prevent myself from moving into a therapeutic stance. However, at the same time I utilised my therapeutic skills to enable women to talk in a way that they told me was empowering.

3.5. Use of interpreters

Within inter-cultural research, language barriers can pose particular difficulties when conducting interviews (Schroer, 2009) and this was certainly a consideration with the present research. Whilst some of the participants were very fluent in English, others required an interpreter. When using interpreters, there was a choice regarding, which approach I took. I initially set out to use a traditional positivist approach to working with interpreters as it is the predominant model used in qualitative research and I considered it most appropriate for my research (Edwards, 1998). In line with this, I had intended the interpreters to translate the interview word-for-word whilst transmitting neutral and non-influential messages to the participants (Temple, 2002). In practicality, this proved hard to implement. Due to the idiosyncratic language used between cultures to describe the practice of FGM, the interpreters informed me that often women's narratives could not be translated directly. This led to a revision of the approach being used and a social constructionist approach was adopted, where the translators acted as interpretative guides (Shklov, 2007). Carrying out the research with interpreters in this way created its own challenges and influences on the process. By conveying meaning between myself as the interviewer and the interviewee rather than literally translating words, a shared understanding between myself, the interviewee and interpreter was attained (Kapborg &

Berterö, 2002). I also wondered if it helped the participants to feel more at ease. However, the downside to this approach lay in the potential misinterpretation of my questions. Furthermore, when translating participant's responses, it was evident that sometimes the interpreter would reduce the content of what had been said. This could have led to some information being omitted based on what the interpreter considered to be unimportant. Leaving out information considered to be 'informal' is a common concern within cross-language research (Aranguri, Davidson, & Ramirez, 2006). Future research in this area may seek to consider more closely the role of interpreters and the potential for bias the differing epistemological approaches can lead to.

A further difficulty relating to the use of interpreters involved the potential for vicarious trauma. In line with the BPS Code of Conduct (2009), I fully debriefed all of the interpreters following each interview however I found this part of the research process challenging. Many of the interpreters disclosed that they themselves were survivors of FGM and therefore listening to the interviewees experience was a narrative they had experience of themselves. On some occasions, the interpreter was quite resistant to the debriefing which left me feeling powerless and conflicted. I considered it essential that I continue to debrief the interpreters even if they felt it was not required, however I also appreciated their views and wished to allow them to maintain a position of control.

The use of interpreters brought to my awareness the complexities of different approaches that could be taken when working with different languages. Previously I had not considered the interpreter as a mechanism to providing a shared conceptualisation and had instead viewed them as a means to facilitate literal understanding within the interview. Taking a social constructionist approach highlighted the dual dimensional role that an interpreter can take; that of a linguist, and that of a co-researcher.

3.6. Ethics, counter-transference and mirrored processes

Despite being carried out ethically and sensitively, the study faced several ethical dilemmas. One of the main ethical issues was the potential for women to feel distressed by the interview. Although participants were provided with a copy of the interview schedule prior to it, as Fontes (2004) argues, I could not always predict the impact recalling a traumatic event might have on each of the women I spoke to. During the interviews, women often became upset at recalling their experience of FGM. Seeing the women feel distressed and tearful I often felt a desire to circumvent asking further questions. Whilst time was given in the interview to help manage women's distress and allow the interview to be stopped if needed, at these times, I also wondered if the disempowerment I felt reflected women's feelings following experiencing FGM.

There were also times during the interviews that I experienced strong counter-transference of anger at those responsible for carrying out FGM on the women I spoke to, as well as regularly feeling overwhelmingly sad, often to the point of tears. The counter-transference I experienced initially frightened me, and I was fearful that my emotional responses could seem inappropriate to the women. By containment of both my and women's emotions during the interview, showing how touched I was by their experience, appeared to assist them to talk openly and to validate their narratives.

As a result of transference, the fluctuation in my emotions during the interviews appeared to mirror those the women felt due to the impact of FGM. The results of the study indicated that fear influenced both the emotional impact of FGM, as well as women's ability to show resilience. I feel this was emulated in my sometimes-reduced ability to ask difficult questions when carrying out interviews, for fear that certain questions may cause distress in women. As the interviews progressed I was able to manage this more easily through the use of supervision, however I felt it mirrored the way many of the women described using avoidance to cope with the emotional impact of FGM. Conversely, at

other times the same fear led me to show resilience, creating an increased sense of duty to complete the interview as I had originally intended. Many of the women described key stages in their lives as causing them to struggle emotionally, however they all described how the same experiences often also led them to build their resilience. On reflection I wonder if the fluctuation I experienced between avoidance and resilience was reflective of the everyday experiences of women I interviewed.

3.7. Empowerment

One of the most powerful aspects of my research with survivors of FGM was the amount of trust they placed in me, in line with their response to being interviewed. When speaking to the women about what they felt would help, three women stated that until this interview they had not considered talking about their experiences to be beneficial in any way. The process of taking part in the research appeared to have provided a safe space for allowing women to experience sharing their story in a way they felt was empowering and helpful. This is consistent with feminist research methods in which the role of taking part in research can also serve to empower women participants.

Some women had never shared their experiences before, and I felt truly moved that they felt able to do so with me. Other women I spoke to told me they had shared parts of their story, but had not considered in detail the impact of their experience of FGM.

In order to illustrate the participant's views of the impact of taking part in the research, I will draw on powerful verbatim quotations made by three of the participants. Faridah (Lines 457-459) expressed that even though she had received psychological support:

In one session with you [myself as the researcher], you have taken me to a place I didn't cover in 6 years of therapy, so every woman who has gone through FGM should have this chance to really talk about what happened to them.

Keisha (Lines 64-65) voiced that she:

Would love someone to talk to me like you [Myself as the researcher] are, to listen and respond and really care...I don't know what it is, but the way you listen...we need more people like you, to talk and show that people can be trusting.

Finally, Saskia (Lines 98-100) stated:

It sounds strange but I don't think I realised how much talking helped until we did this today. You seem so much to care and I can see your face that you care and are impacted by what I say. If it hadn't been today I would say no-one can help me. But you...no you, talking may be an answer I had not yet considered.

Although I had found all the interviews moving, my clinical experience allowed me to attend and be sensitive to the emotional needs of the participants, whilst the researcher part of my role allowed me to progress the interview forward and gain the information I needed relevant to the study questions. However, when I was told by women I spoke to that I had changed their view on the value of talking therapies, partly due to the empowering impact the research interview had, I was visibly lost for words. The empowerment women described was a key theme emerging from the data, and one that I felt paralleled my own experience of carrying out the research. Similar to the women initially following FGM, at the start of the research journey, I felt very anxious and powerless. However, also mirroring the participant's shift in feelings throughout their lives, having conducted interviews, I felt empowered due to the impact of women's views

suggesting I had aided them to see the positive side to talking through their experiences. Furthermore, their words forced me to appreciate the powerful roles a qualitative researcher has and the potential to empower individuals through this process (Lather, 1988).

3.8. Sense of duty

Regularly throughout the research process, I felt a strong sense of moral and ethical duty towards women I was interviewing, the subject area, and my integrity as a researcher. Feelings of duty were the most pronounced during the data collection and analysis phases of the research. As previously discussed, many of the women participants experienced an emotional response during the interview. Although all the women were fully debriefed and received information about support services, I regularly found myself feeling a sense of duty to contact the participants at a later point to check that they were okay. Whilst for some women I had pre-arranged that I would do this, due to the level of distress they exhibited during the interview, for others I made the decision that it would not have been appropriate to contact them outside of pre-arranged times. I found being unsure about how they were very unsettling and spent considerable time wondering why I was struggling to maintain clear boundaries between my professional and personal life. I wondered again if this pull to offer support to the women was a result of counter-transference. Many of the women I spoke to described feeling let down and unprotected by their mothers and I believe this led to my taking on a protector role. Effective supervision with my research team helped me to make sense of, and manage this.

Analysis of the interview data also led me to feel a sense of duty towards the participants. The women who spoke to me had shared so much information relating to their experience of having FGM, it felt overwhelming trying to formulate their narratives into a model that

did justice to all of their voices. I noted the duty I felt to accurately represent participants' experiences further echoed in the theoretical model developed from the interviews. Women described becoming more resilient following FGM by developing a sense of duty to advocate against, and resist its practice. The sense of duty I felt towards the women I interviewed led me to carry out the research in the first instance, as well as my future desire to utilise my research to promote the needs of FGM survivors to services.

Fuelling my sense of duty was my admiration and respect for women who took part in the study. Had the tables been turned, I wondered if I would have been able to speak with their openness and honesty about such an intimate and traumatic experience. With this admiration also came a personal desire, in addition to the theoretical need to accurately represent the women's narratives.

A crucial part of the research process involved attaining feedback from women participants regarding the results and analysis of the data (Mays and Pope, 2000). From the outset of the study, I was aware of participant comments that they had regularly experienced feeling judged and stigmatised by health care professionals in the United Kingdom. I distinctly recall Saskia (Line 75) stating that when giving birth to her child, the medical doctors had been unfamiliar with the practice of FGM. She related her experience: "they just laughed and said some cultures are silly. I felt this big...as though I wish I was dead". These words echoed in my head whilst analysing the data and I felt it essential to provide women with a positive experience of health care professionals through the research process. Whilst not all participants could be contacted due to language limitations, respondent feedback demonstrated women were in agreement with the conclusions drawn from the data and were positive about the model generated.

The experience of having my analysis validated by participants was new to me, and showed me how valuable this is within qualitative research.

3.9. Conclusion

The process of reflecting on my research journey enabled a more detailed understanding of some of the complex reflective, methodological and ethical issues that can occur when carrying out ethnographic, sensitive research including challenges to recruitment, negotiating my position as a researcher, and working with interpreters. Considering participant's and my own responses to the interviews allowed a deeper understanding of the strong impact that participants can have personally on the researcher and vice-versa and strategies to manage this process. Reflecting on the research process has highlighted the importance of a reflexive approach when carrying out qualitative research, as well as allowing for personal, as well as professional development. It has further highlighted the value of both researcher and psychological skills when carrying out sensitive research in a way that aims to facilitate further empowerment of participants.

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Appendix A: Journal of International Women's Studies general submission guidelines

Submit your article to JIWS@bridgew.edu. Reviews typically take 3-6 months.

Only completed work should be submitted. The editors cannot provide feedback on work in progress.

Abstracts and key words should be included in the same file as the article.

Authors should include a key word or phrase about their research methodology.

The maximum length of any contribution should be 7,500 words, inclusive of notes and bibliography.

Contributions should be double-spaced, including all notes and references. Page numbers should be placed in the upper-right corner, paragraphs should be indented, and all illustrations and tables should be labeled and captioned accurately. Use Times New Roman, 12 point font, left-justified text, and bold-faced headings. Follow APA or MLA citation styles.

All submissions should include an abstract of 300 words or less and three key words suitable for indexing and abstracting services.

Final submissions following revisions should be single spaced; right justified; bold headings with no space between heading and paragraph including title and abstract; the phrase key words should be italicized; references/bibliographies should be single spaced with hanging paragraphs. Authors should consult recent editions for guidelines and send inquiries to the editor.

In the interests of double-blind reviewing, only the title of the paper should appear on the first page. Authors should include their name and affiliation and any acknowledgements on a separate page.

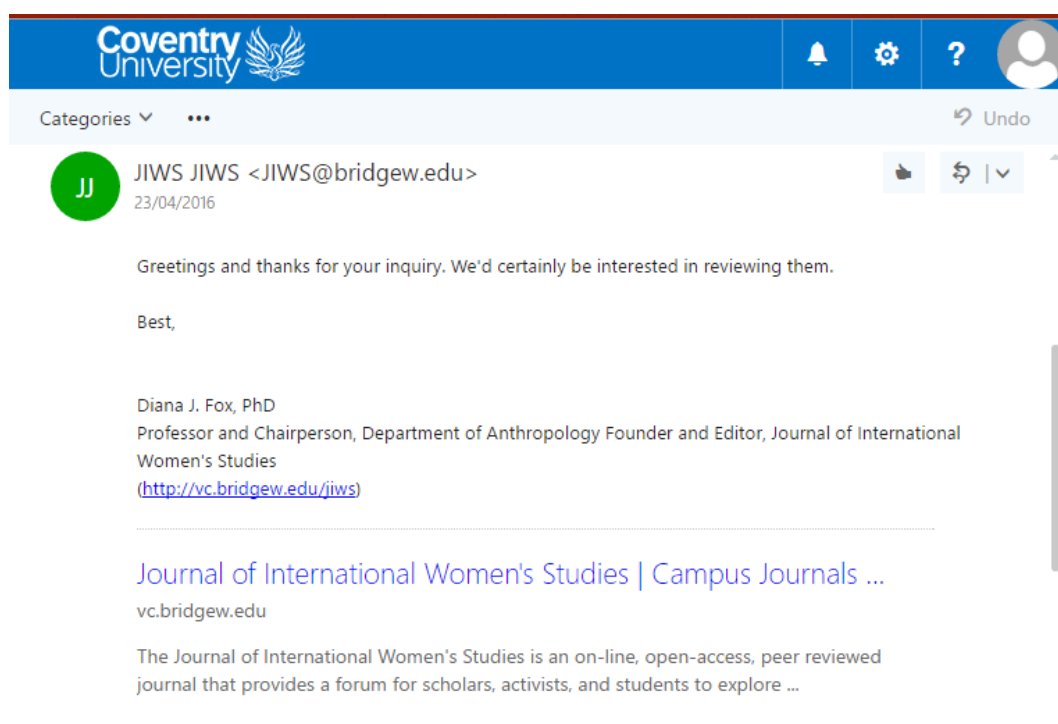
A brief biographical note of not more than 80 words about each author should be supplied on a separate page.

Contributors should bear in mind the international nature of the journal's audience. Endnote explanations are necessary for all political & geographic references, popular culture references, as well as academic references. Please do not assume that scholars who are famous in one country bear similar prestige elsewhere.

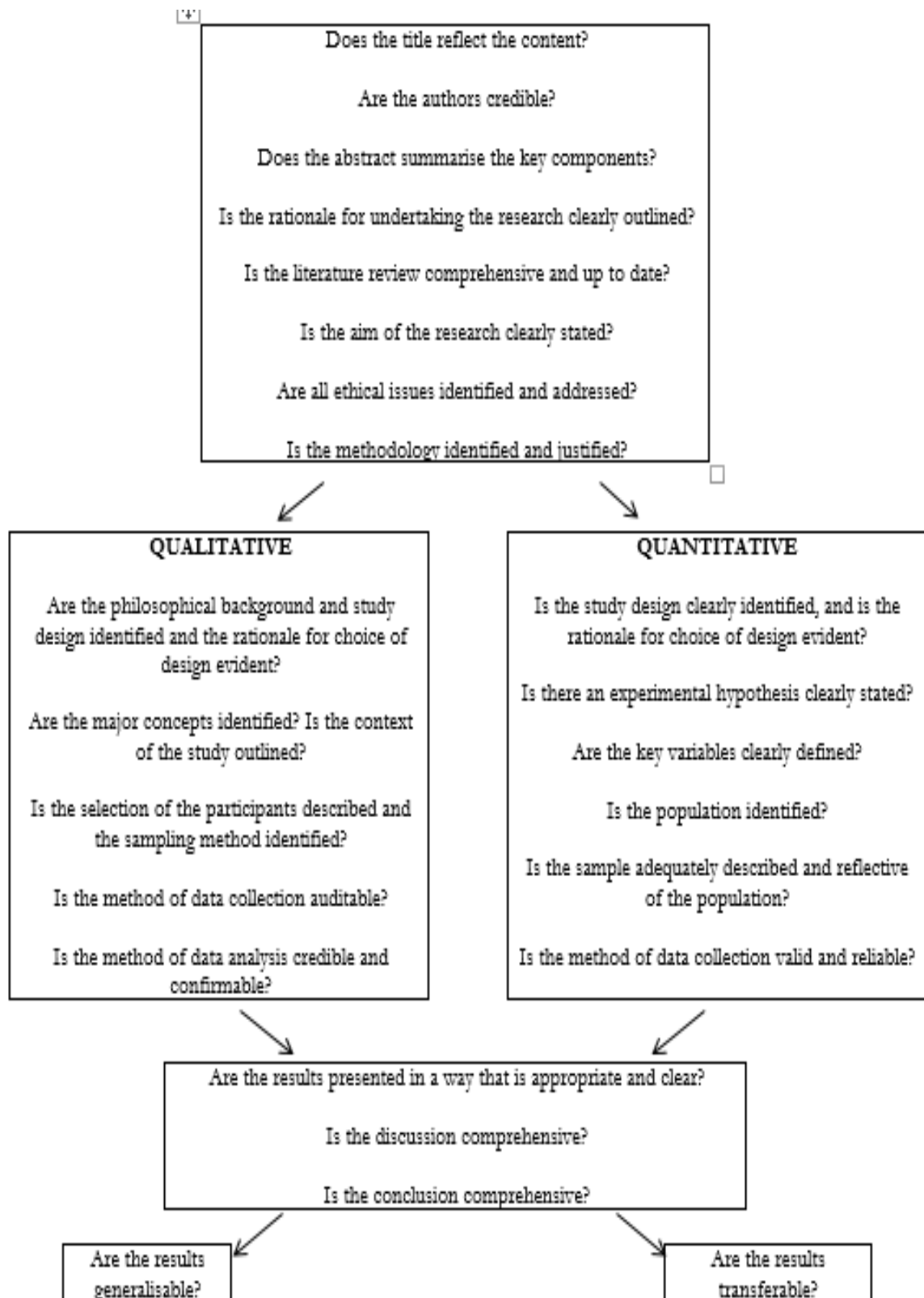
Submission of work to this journal will be taken to imply that it presents work not under consideration for publication elsewhere. On acceptance of work, the authors agree that the exclusive rights to reproduce and distribute the article have been given to **JIWS**.

Permission to extensively quote from or reproduce copyright material must be obtained by the authors before submission and any acknowledgements should be included in the typescript, preferably in the form of an Acknowledgements section at the beginning of the paper. Where photographs or figures are reproduced, acknowledgement of source and copyright should be given in the caption.

Email from Editor



Appendix B: Critical assessment framework



Appendix C: Quality assessment scores

| Quality indicator | Chavada & Diamond-Smith, et al (2000) | Lei and Pals (2011) | Uddin (2015) | Karmaker et al (2014) | Mohammed et al (2014) | Adevale and Abdelshahid & Bogale et al (2014) | Debhankhali et al (2017) | Besera and Roess (2017) | Tamire and Molla (2013) | Ahanonu and Yasin et al (2013) | Modrek and Liu (2013) | Hossain et al 2015 | Ghosh (2011) | Nasrullah et al (2014) | Kapadia et al (2015) | Matlabi et al (2013) | Chung (2007) |
|--|---------------------------------------|---------------------|--------------|-----------------------|-----------------------|---|--------------------------|-------------------------|-------------------------|--------------------------------|-----------------------|--------------------|--------------|------------------------|----------------------|----------------------|--------------|
| Does the title reflect the content? | 2 | 2 | 1 | 2 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 1 |
| Are the authors credible? | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 2 | 2 | 2 | 1 | 2 | 2 |
| Does the abstract summarise the key components? | 2 | 2 | 0 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 1 | 2 | 2 | 2 | 2 |
| Is the rationale for undertaking the research clearly outlined? | 2 | 2 | 1 | 2 | 2 | 1 | 1 | 2 | 1 | 2 | 1 | 1 | 1 | 2 | 2 | 2 | 2 |
| Is the literature review comprehensive and up-to-date? | 1 | 1 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 1 | 1 | 2 | 1 | 1 | 2 |
| Is the aim of the research clearly stated? | 2 | 2 | 1 | 2 | 2 | 1 | 1 | 1 | 2 | 2 | 2 | 1 | 1 | 2 | 1 | 1 | 1 |
| Are all ethical issues identified and addressed? | 1 | 1 | 0 | 2 | 1 | 1 | 2 | 1 | 0 | 1 | 1 | 2 | 0 | 1 | 1 | 0 | 1 |
| Is the methodology identified and justified? | 1 | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 1 | 2 | 2 | 1 | 1 | 2 | 1 | 2 | 2 |
| Is the study design clearly identified, and is the rationale for choice of design evident? | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 1 | 2 | 2 | 1 | 2 | 2 |
| Is there an experimental hypothesis clearly stated? | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 2 |
| Is the population identified? | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Is the sample adequately described and reflective of the population? | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 2 |
| Are the key variables clearly defined? | 2 | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 1 | 2 | 2 | 1 | 2 | 1 | 2 | 2 |
| Is the method of data analysis valid and reliable? | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Are the results presented in a way that is appropriate and clear? | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 1 | 1 | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 2 |
| Is the discussion comprehensive? | 1 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 1 | 1 | 2 | 1 | 1 | 1 |
| Are the results generalisable? | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 1 |
| Is the conclusion comprehensive? | 1 | 2 | 1 | 1 | 0 | 2 | 1 | 1 | 1 | 2 | 1 | 1 | 2 | 2 | 1 | 1 | 2 |
| TOTAL | 30 | 34 | 29 | 31 | 30 | 29 | 31 | 29 | 28 | 30 | 33 | 27 | 30 | 28 | 23 | 28 | 31 |
| Percentage | 83 | 94 | 80 | 86 | 83 | 80 | 86 | 80 | 77 | 83 | 91 | 68 | 83 | 77 | 63 | 77 | 86 |

Appendix D: Quality assessment framework inter-rater reliability scores

Paper 1

Case Processing Summary

| | Cases | | | | | |
|-------------------|-------|---------|---------|---------|-------|---------|
| | Valid | | Missing | | Total | |
| | N | Percent | N | Percent | N | Percent |
| Rater 1 * Rater 2 | 18 | 100.0% | 0 | 0.0% | 18 | 100.0% |

Rater 1 * Rater 2 Crosstabulation

| | | Rater 1 | | Total |
|---------|------|---------|------|-------|
| | | 1.00 | 2.00 | |
| Rater 2 | 1.00 | 6 | 0 | 6 |
| | 2.00 | 1 | 11 | 12 |
| Total | | 7 | 11 | 18 |

Symmetric Measures

| | | Value | Asymp. Std. Error ^a | Approx. T ^b | Approx. Sig. |
|----------------------|-------|-------|--------------------------------|------------------------|--------------|
| Measure of Agreement | Kappa | .880 | .116 | 3.761 | .000 |
| N of Valid Cases | | 18 | | | |

Paper 2

Case Processing Summary

| | Cases | | | | | |
|-------------------|-------|---------|---------|---------|-------|---------|
| | Valid | | Missing | | Total | |
| | N | Percent | N | Percent | N | Percent |
| Rater_1 * Rater_2 | 18 | 100.0% | 0 | 0.0% | 18 | 100.0% |

Rater 1 * Rater 2 Crosstabulation

| | | Rater_2 | | | Total |
|---------|------|---------|------|------|-------|
| | | .00 | 1.00 | 2.00 | |
| Rater_1 | .00 | 1 | 0 | 0 | 1 |
| | 1.00 | 0 | 4 | 1 | 5 |
| | 2.00 | 0 | 1 | 11 | 12 |
| Total | | 1 | 5 | 12 | 18 |

Symmetric Measures

| | | Value | Asymp. Std. Error ^a | Approx. T ^b | Approx. Sig. |
|----------------------|-------|-------|--------------------------------|------------------------|--------------|
| Measure of Agreement | Kappa | .766 | .158 | 3.813 | .000 |
| N of Valid Cases | | 18 | | | |

Paper 3

Case Processing Summary

| | Cases | | | | | |
|-------------------|-------|---------|---------|---------|-------|---------|
| | Valid | | Missing | | Total | |
| | N | Percent | N | Percent | N | Percent |
| Rater_1 * Rater_2 | 18 | 100.0% | 0 | 0.0% | 18 | 100.0% |

Rater_1 * Rater_2 Crosstabulation

Count

| | | Rater_2 | | Total |
|---------|------|---------|------|-------|
| | | 1.00 | 2.00 | |
| Rater_1 | 1.00 | 6 | 0 | 6 |
| | 2.00 | 2 | 10 | 12 |
| Total | | 8 | 10 | 18 |

Symmetric Measures

| | | Value | Asymp. Std. Error ^a | Approx. T ^b | Approx. Sig. |
|----------------------|-------|-------|--------------------------------|------------------------|--------------|
| Measure of Agreement | Kappa | .769 | .150 | 3.354 | .001 |
| N of Valid Cases | | 18 | | | |

Overall inter-rater reliability

Case Processing Summary

| | Cases | | | | | |
|-------------------|-------|---------|---------|---------|-------|---------|
| | Valid | | Missing | | Total | |
| | N | Percent | N | Percent | N | Percent |
| Rater_1 * Rater_2 | 54 | 100.0% | 0 | 0.0% | 54 | 100.0% |

Rater_1 * Rater_2 Crosstabulation

| | | Rater_2 | | | Total |
|---------|------|---------|------|------|-------|
| | | .00 | 1.00 | 2.00 | |
| Rater_1 | .00 | 1 | 0 | 0 | 1 |
| | 1.00 | 0 | 16 | 1 | 17 |
| | 2.00 | 0 | 4 | 32 | 36 |
| Total | | 1 | 20 | 33 | 54 |

Symmetric Measures

| | | Value | Asymp. Std. Error ^a | Approx. T ^b | Approx. Sig. |
|----------------------|-------|-------|--------------------------------|------------------------|--------------|
| Measure of Agreement | Kappa | .805 | .083 | 6.313 | .000 |
| N of Valid Cases | | 54 | | | |

Appendix E: Certificate of ethical approval



Certificate of Ethical Approval

Applicant:

Jennifer Glover

Project Title:

Psychological Effects of Female Genital Mutilation

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

18 December 2014

Project Reference Number:

P29554

Emotional impacts of female circumcision Research Opportunity

We are currently carrying out research into the psychological impacts of circumcision and are looking for women who have had this experience who would be willing to take part in individual discussions about their experience of this.

It is hoped that the research will provide information which will inform services on how best to support women.

If you would be willing to share your experience of being circumcised or would like more information about this research, please contact and I will happily answer any questions:

Jennifer Glover

Trainee Clinical Psychologist

*Researcher for a Doctorate in Clinical Psychology and currently
working as a clinical practitioner in mental health services*

Email: gloverj6@uni.coventry.ac.uk

Appendix G: Participant recruitment leaflets

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D, CPsychol



Research Opportunity

My name is Jennifer and I am currently a Trainee Clinical Psychologist. I spend 3 days week working in clinical settings, and two days a week doing research and studying.

Before I started this training, I was working in clinical practice with people who have experienced all different kinds of trauma and difficult experiences.

As part of my training, I am carrying out research into the emotional impacts of female circumcision. I realised that this was an area which needed research having worked with two female clients who were survivors and who were experiencing emotional, family and relationship problems after having female circumcision.

I realised then that there was very little support for women who have experienced this. In order to develop services to support survivors, we have to do research to understand how female circumcision may impact women. To understand this, I would like to speak to survivors of female circumcision who would be willing to share their experience with me.

I understand that this is a very difficult thing to talk about and I can assure you that you would remain anonymous at all times. If you do not wish to give me your real name that is fine. The interviews would be recorded and then analysed by myself. It would only be me that would listen to the tapes. As a trainee clinical psychologist, I am able to support you throughout the interview and afterwards if you need.

If you feel you are able to share your experience with me, then please contact me on the number below. I would be grateful to hear from you and hope we can work towards better support services for survivors.

Jennifer Glover
Email: gloverj6@uni.coventry.ac.uk

Dean of Faculty of Health and Life Sciences
Professor Guy Daly Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805
Head of Department of Psychology
Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

www.coventry.ac.uk

Appendix H: Participant information sheet

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF
WARWICK



Participant Information Sheet

Study Title: Psychological Impact of FGM

Researcher: Jennifer Glover, Trainee Clinical Psychologist

I would like to ask for your assistance with a research study that I am conducting. The study aims to understand the psychological impact of FGM. Before you decide whether to take part you need to understand why the research is being done and what it would involve for you to take part. Please take time to read the following information carefully.

Why have I been invited to take part?

Women who are survivors of FGM and who currently reside in the United Kingdom have been invited to take part in this study. You have been invited to take part in this study because you meet these criteria.

How many will be interviewed in the study?

It is hoped that around 15 – 25 women will participate in individual semi-structured interviews or in a focus group discussion.

What is the purpose of the study?

Previous research has indicated that FGM is likely to have psychological effects, however the effects of FGM have not yet been studied in depth. It is hoped that this study will help to understand the psychological impact of FGM and hence help improve current services to more closely meet the needs of FGM survivors.

Do I have to take part?

It is up to you to decide, there is no pressure to take part in the research and your decision will not affect any current or future access to services. Please read through this information sheet and if you are interested in taking part in the research or in finding out more about it I would greatly appreciate you getting in contact with me to discuss this further.

What do I have to do?

This is a qualitative study. You can attend a focus group and/or an individual semi-structured interview with the researcher. An interpreter will be present if your first language is not English and you feel it could help you communicate your answers. If you choose to participate in a focus group, these will involve between 6-10 women survivors of FGM plus the researchers and an interpreter. The interviews will be held at a mutually convenient time and place as agreed with you. The interview will be audio recorded, however all information will be treated as confidential and you will not be identifiable in any publications. You will be asked to consent to be involved, recorded and the audio tape being used for the research. You will need to supply some basic demographic details, and talk about your experiences of FGM. It is a chance for you to share your thoughts and feelings about your experiences and how you feel services could best support those who have undergone FGM living in the UK. Every care will be taken to minimise distress and you can choose what you wish to share with me. At the end of the session you will receive contact details of sources of support that are available. The interview will last approximately 60 minutes in duration depending on how much you wish to talk. The entire session including completing consent forms, demographic information and the interview itself will last around 90 minutes.

Dean of Faculty of Health and Life Sciences
Professor Guy Daly, Coventry University, Priory Street, Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology
Professor James Tresilian BSc PhD, University of Warwick, Coventry CV4 7AL Tel 024 7657 3009

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Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

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WARWICK



What are the benefits and disadvantages of taking part?

I cannot promise that the study will help you but the information obtained could assist in informing the further development of culturally specific support services for FGM survivors. The one-to-one discussion also provides a chance for you to tell your story and add to existing knowledge in this field. Some people may find this to be a rewarding or upsetting experience, but it is entirely up to you what and how much information you choose to share with me. As a psychologist, I will be able to provide you with support during and after your interview.

What if I agree to take part and then wish to withdraw from the study?

You can withdraw from the study at any time, up until the research is completed, without giving a reason and without it affecting your care from services. You can do this through contacting the key researcher on the contact details provided.

Will my participation in the study and data be kept confidential?

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence in accordance with the Data Protection Act 1998. Audio taped and demographic data will be stored securely in locked premises. Pseudonyms will be used instead of your own name in order to protect your anonymity. All information which is collected about you during the course of the research will be kept strictly confidential, and information about you will not have your personal details on so that you cannot be recognised. Some parts of this data may be looked at by authorised persons from the University to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant. The information you give as part of the research process will be analysed and used only as part of this study. Confidentiality may only be broken if the researcher is concerned regarding you or someone else coming to harm; this is rarely necessary and we would always endeavour to speak to you about these concerns before breaking confidentiality. When the study is completed data generated by the study will be stored in a confidential place at Coventry University for five years and then destroyed.

What will happen to the results of the research study?

It is intended for the results of the study will be written up as part of the researchers Doctorate in Clinical Psychology. Findings to be submitted for publication following its completion in March 2016. You will be able to receive a summary of the results.

Who is organising/funding the research?

The research is being carried out by Jennifer Glover, trainee Clinical Psychologist at Coventry and Warwick Universities. The research is being supervised by Dr Helen Liebling, (hsx497@coventry.ac.uk); Professor Hazel Barrett (h.barrett@coventry.ac.uk) and Dr Simon Goodman (s.goodman@coventry.ac.uk), Coventry University.

Who has reviewed the study?

This study has been approved by Coventry University Ethics Committee and National Research Ethics Service.

Dean of Faculty of Health and Life Sciences
Professor Guy Daly Coventry University Priority Street Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology
Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

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Dr Eve Knight
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THE UNIVERSITY OF
WARWICK



What if I have any question or concerns?

For further information or concerns you may have about any aspect of the study, you can contact Jennifer Glover using the contact details below, who will do her best to answer your questions. If at any point you remain unhappy and wish to complain formally, you can do this through the University complaints procedure, details of which can be obtained from the researcher. You can also contact the research supervisors listed above.

What do I do now?

If you are interested in taking part in the research or in finding out more about it, I would be very happy to hear from you. Please contact me on the details below and I will be happy to discuss this further with you. Please note that allowing me to contact you does not mean that you have to take part.

Thank you very much for your time.

Jennifer Glover
Principal Researcher
Trainee Clinical Psychologist
Coventry and Warwick Universities
E-mail: gloverj6@uni.coventry.ac.uk

Dean of Faculty of Health and Life Sciences
Professor Guy Daly Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology
Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

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Appendix I: Participant consent form

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF
WARWICK



Participant Informed Consent Form

Title of Study: Psychological Impacts of FGM

Name of Researcher: Jennifer Glover

Participant's Pseudonym:

Please initial box

1. I confirm that I have read and understand the Information Sheet for the above study. I have had the opportunity to consider the information provided and ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw up until December 2015, without giving any reason, and without my medical or legal rights being affected. ☐
4. I understand that interviews will be recorded and that *anonymous* direct quotes from the interview may be used in the study report. ☐
5. I agree to the use of audio recording ☐
6. I wish to receive a written summary of the findings of the study ☐
7. I understand that the information provided during the interview may be used anonymously in a published version of the research outcomes. ☐
8. I understand that if I disclose information suggesting that I or anybody else may be at risk of physical harm, information relating to a hospital security breach or crimes that I have not been convicted of then this information will be passed on to my clinical team. ☐
7. I agree to take part in the above study. ☐

Name of participant:

Signature of participant:

Date:

Name of Researcher:.....

Signature of researcher:

Date:.....

Dean of Faculty of Health and Life Sciences

Professor Guy Daly Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Head of Department of Psychology

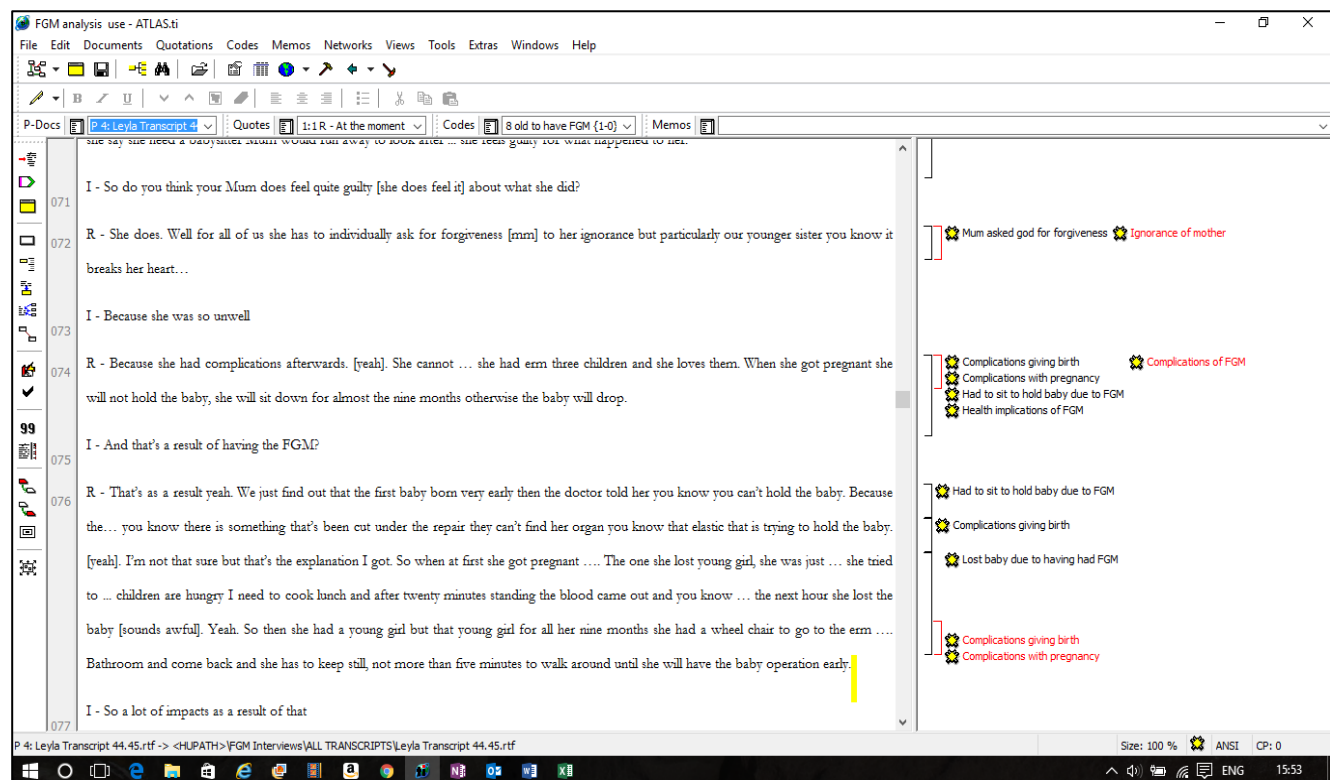
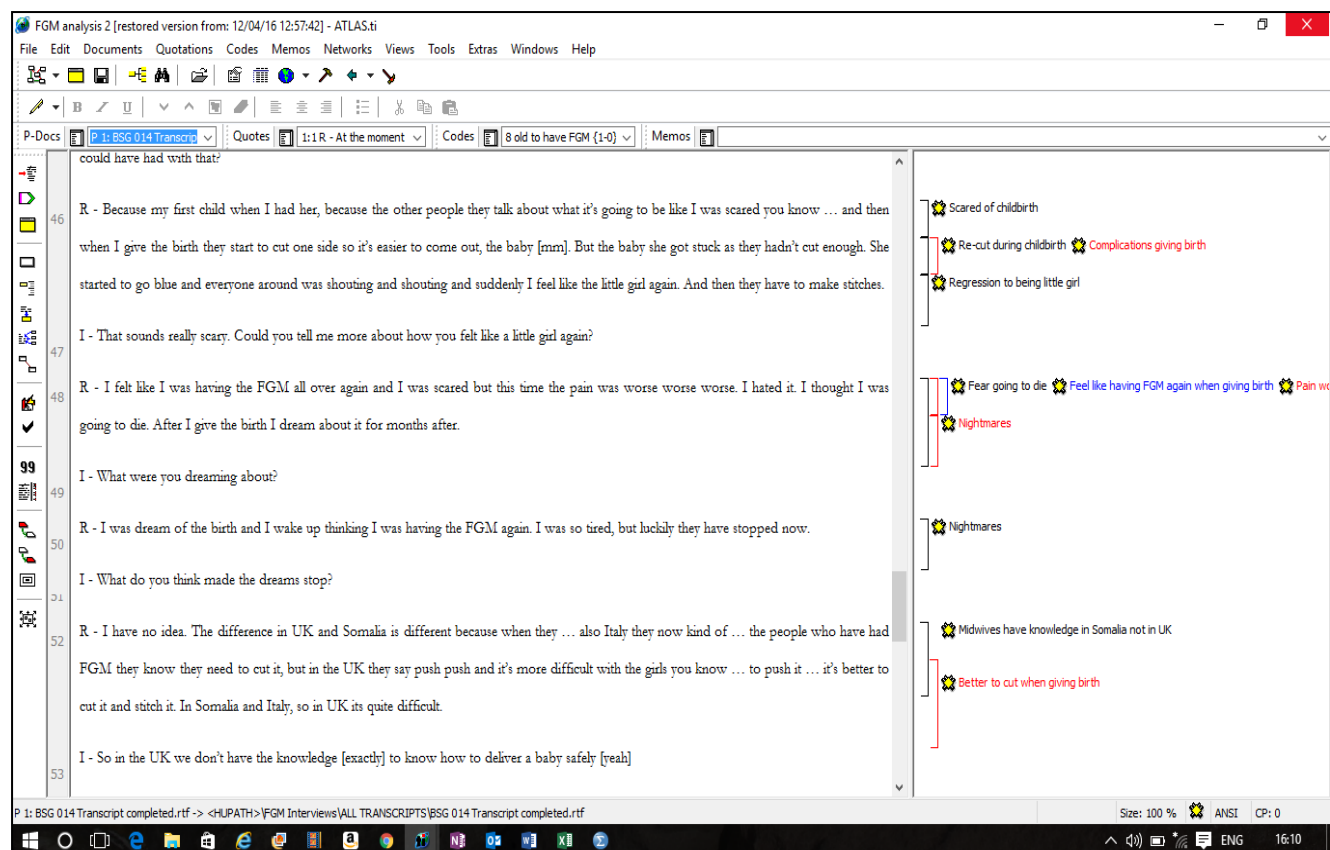
Professor James Tresilian BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7657 3009

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Appendix J: Interview schedule

| | | | |
|---|--|---|--|
| Study Title: | Psychological Impact of FGM | | |
| Researcher: | Jennifer Glover, Trainee Clinical Psychologist | | |
| | <ul style="list-style-type: none"> • Intro to research and ensure participant is ok • How are you today? • Did you get here ok today? • Can you tell me a bit about your current life? <ul style="list-style-type: none"> ○ Occupation ○ Family ○ Living arrangements • You are aware of what we are talking about today, could you tell me what term you use to describe this experience? And why? • Experiences of having Female Genital Mutilation?^{**} <ul style="list-style-type: none"> ○ What aspects are most vivid in your memory? • Do you feel your experiences has affected your life? • In what ways has FGM impacted your life? | | |
| Prompts: | <i>Physical effects</i> <i>Positive impacts</i> <i>Psychological effects</i> <i>Identity</i> <i>Femininity</i> <i>Re-experiencing symptoms</i> | <i>Depression</i> <i>Anger</i> <i>Emotional effects</i> <i>Social effects</i> <i>Family</i> <i>Sexuality</i> | <i>Suicidal</i> <i>Relationships</i> <i>Cultural effects</i> <i>Resilience</i> <i>Children</i> |
| | <ul style="list-style-type: none"> • Impact of being in the UK compared to home country <ul style="list-style-type: none"> ○ How is it different? ○ Loss of family ○ Cultural opinions about FGM – in the UK, media • How do you think life would be if you hadn't had FGM? • What do you think the reasons were for you having FGM? <ul style="list-style-type: none"> ○ Are you grateful for having FGM? ○ Do you blame anyone for having FGM? • What are the benefits, if any, of having FGM? • How do you feel you have been able to manage the impact of your experiences? If so what has helped you deal with these effects? | | |
| Prompts: | <i>Resilience</i> <i>Counselling</i> <i>Women's organisations</i> | <i>Family Support</i> <i>Legal / Justice</i> <i>Cultural/customary support structures</i> | |
| | <ul style="list-style-type: none"> • What has your experiences of support services been like? (if services accessed) | | |
| Prompts: | <i>Helpful/ not helpful</i> <i>Listened</i> | <i>Gender</i> <i>Sensitive to stigma/shame/ culture</i> | |
| | <ul style="list-style-type: none"> • Are there still aspects of your experience which still trouble you? • What do you think services could offer survivors? • Is there anything that you would like to add about your experience of FGM? | | |
| Thank you very much for your time and participation in our research. | | | |
| Debrief | | | |
| ^{**} The term FGM will be substituted dependent upon term felt most appropriate by the participant | | | |

Appendix K: Example of analysis on Atlas Ti



Appendix L: Grounded theory analysis

| Conceptual coding | Axial coding | Open coding |
|----------------------|-------------------|--|
| Understanding of FGM | Lack of knowledge | <p>Did not realise FGM could impact giving birth</p> <p>Did not realise problems with FGM until got married did research into FGM</p> <p>Didn't realise problems were because of FGM</p> <p>Didn't used to make connection between health problems and FGM</p> <p>Knowledge of FGM</p> <p>Lack of understanding</p> <p>Mother didn't know FGM caused problems</p> <p>Don't realise FGM is a type of abuse</p> |
| | Religion | <p>Did not impact religion beliefs</p> <p>FGM not good for religion</p> <p>If not for religion then no point in FGM</p> <p>If religious would agree with FGM</p> <p>Makes religion look bad</p> <p>Not all Muslims practice FGM</p> <p>Nothing to do with religion</p> <p>Nothing to indicate FGM should be carried out like other religious practises</p> <p>People are lying about religion</p> <p>Religion cannot explain practice</p> <p>Shocked that FGM has nothing to do with religion</p> <p>Told FGM was for religion</p> |
| | Role of men | <p>FGM for men</p> <p>FGM for male pleasure</p> <p>FGM good for men</p> <p>Dad wanted me to have the FGM</p> <p>Cannot marry without FGM</p> <p>Pressure on man to marry girl with FGM</p> |
| | Culture | <p>Pressure from culture</p> <p>Pressure from grandparent's cultural beliefs</p> <p>Pressure from neighbours and others in society</p> <p>Pressure to have daughters cut</p> <p>Powerless to stop culture</p> <p>Pressure from cutter</p> <p>Cutter idolised within culture</p> |
| | Deception | <p>Children taken and cut without parent knowing</p> <p>Deceived into thinking was a party</p> <p>Should need parental consent</p> <p>Dad went behind Mum's back</p> <p>Husband went behind back to get daughter cut</p> |
| | Female Identity | <p>Had to go through this just because a woman</p> <p>Markers of being a woman in life</p> <p>Punished for being a women</p> <p>Suffer for being a woman</p> |
| | Feeling different | Desire to be seen as normal |

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| Impact of Identity | | <p>Different to normal people</p> <p>Don't feel normal</p> <p>Don't want special treatment</p> <p>Feel different</p> <p>Feel like people are staring</p> <p>Feeling like a freak</p> <p>Other people's vagina beautiful compared to mine</p> <p>Upset at feeling different</p> <p>Why me</p> <p>Women with FGM face more problems than those without it</p> |
| | Identity as a woman | <p>Did not feel like a woman</p> <p>Femininity</p> <p>FGM not part of being a woman</p> <p>Had to go through this just because a woman</p> <p>Punished for being a woman</p> <p>Suffer for being a woman</p> <p>Women shouldn't hurt each other</p> <p>Reality of being a woman</p> <p>Confused sexuality</p> |
| | Loss of childhood identity | <p>Childhood taken away</p> <p>FGM took childhood</p> <p>Lost childhood</p> <p>Lost childhood due to FGM</p> <p>Miss childhood</p> <p>Missed out on playing with brothers after FGM</p> <p>Culture of child abusers</p> |
| | Unknown Identity | <p>Worry that FGM has broken brain</p> <p>Wonder what life would be like without FGM</p> <p>FGM changed me</p> <p>Would I be different if I hadn't had FGM?</p> |
| Emotional impact | Anger | <p>Anger</p> <p>Anger at culture and society</p> <p>Anger at dad</p> <p>Anger at lost childhood</p> <p>Anger at sister for doing FGM after having bad experience</p> <p>Anger causing more damage</p> <p>Anger stayed a long time</p> <p>Anger will never go</p> <p>Anger with name FGC not FGM]</p> <p>Angry at all women</p> <p>Angry at being stigmatised</p> <p>Angry at mother</p> <p>Angry that FGM still going on</p> <p>Angry that people blame religion</p> <p>Angry when see other girls having FGM</p> <p>Angry when see TV campaigns</p> <p>Angry with cutter</p> <p>Can't have photo's of mother as make too angry</p> <p>Misplaced anger towards husband</p> |

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| | | <p>Never get over the anger</p> <p>Understand why people can shoot people</p> |
| | Remembering FGM | <p>Memories of FGM</p> <p>Children crying as a reminder of FGM</p> <p>Experience of FGM always on my mind</p> <p>FGM as very bad memory</p> <p>Lasting memory</p> <p>Media reminds me of own FGM</p> <p>Never forget feeling of being of needing to urinate</p> <p>Never forget FGM</p> <p>Remember being held down</p> <p>Remember cutter shouting at me</p> <p>Remember everything</p> <p>Remember cutters face</p> <p>Remember like was yesterday</p> <p>Remember lining up for FGM</p> <p>Remember pain of urinating</p> <p>Reminded of FGM whenever have health problems</p> <p>Triggers</p> <p>Dissociation</p> <p>Nightmares</p> <p>Avoid sleeping</p> <p>Disorientated due to FGM nightmares</p> <p>Nightmares</p> <p>Still have nightmares</p> <p>Still wake up screaming</p> <p>Daily triggers make me see cutters face</p> <p>Hear cutters voice daily</p> <p>Image of cutter</p> <p>Image of cutter still makes me scared</p> <p>Pain of childbirth brings back memories of FGM</p> <p>Phone to check sister is ok – reliving</p> <p>Regression to being little girl</p> <p>Reliving</p> <p>Reliving FGM</p> <p>Sex - think husband is cutter</p> <p>Sex reminds me of FGM</p> <p>Smell the blood – reliving</p> <p>Still feel pain of when had FGM</p> <p>Still hear drumming of FGM ceremony</p> <p>Still hear screams today</p> <p>Still hear sister screaming now</p> <p>Still see cutter</p> <p>Still see face of cutter</p> <p>Still see it today</p> <p>Still smell the powder</p> <p>Remember sister FGM more than own</p> <p>Remember other people's stories of FGM</p> |
| | Shame | Ashamed |

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| | | <p>Degraded</p> <p>Embarrassed</p> <p>People avoid services as seen as a victim</p> <p>People make judgements because I am Somalian</p> <p>Shame</p> <p>Stigma in UK causes psychological problems</p> <p>Stigmatised based on looks</p> <p>Stigmatised by medical professionals</p> <p>Stigmatised in UK</p> <p>Victimised in the UK</p> <p>Low confidence due to shame</p> <p>Cry where no one can see me</p> |
| | Avoidance | <p>Avoid talking about it to avoid remembering</p> <p>Block it out</p> <p>Don't want to remember FGM</p> <p>Hard to talk about</p> <p>Hard to think about</p> <p>Try to forget FGM to cope</p> <p>Want to ignore feelings</p> <p>Dissociation</p> <p>Somatisation</p> <p>Headaches when think about FGM</p> |
| Relational impact | Attachment with child | <p>Attachment with child impacted</p> <p>Had to sit to hold baby due to FGM</p> <p>Hard to bond with child</p> <p>Resenting child for pain during child birth</p> |
| | Forgiveness | <p>Don't hold FGM against mum</p> <p>Forgiven Mother as know she loved me</p> <p>Never forgive cutter</p> <p>Never forgive mother</p> <p>Obligated to forgive mother</p> |
| | Trust | <p>Difficulties trusting others</p> <p>Do not trust family</p> <p>Do not trust men or women</p> <p>Do not trust women</p> <p>FGM has made me distrustful</p> <p>FGM killed my trust</p> <p>Hate women</p> <p>Keep barriers up from others</p> <p>Life lonely not being able to trust people</p> <p>No friends due to trust</p> <p>Scared to take children to home country</p> <p>Scared to talk about it</p> <p>Scared to trust people</p> |
| | Impact on marital relationship | <p>Avoid being close with husband</p> <p>Avoided talking to husband</p> <p>Strain on relationship</p> <p>FGM not good for relationship</p> <p>Hated husband for marrying a cut girl</p> <p>Have to lie to survive marriage</p> <p>Husband doesn't understand</p> |

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| | | <p>Husband more supportive as wasn't arranged marriage</p> <p>Husband very supportive</p> <p>Impact on relationship</p> <p>Impact on relationship - if he leaves it is due to not having done FGM right</p> <p>Scared to tell husband about pain</p> <p>Avoid sex</p> <p>Could not have penetrative sex</p> <p>Could not satisfy man</p> <p>Couldn't have sex</p> <p>Do not want sex</p> <p>Don't feel comfortable having sex</p> <p>Guilty about lying to husband</p> <p>Guilty that don't feel anything during sex</p> <p>Ignorant to impact of FGM on sexual relationship</p> <p>No choice but to carry on having sex</p> <p>No sexual gratification</p> <p>Pretend to enjoy sex to make man happy</p> <p>Sad because of sexual difficulties</p> <p>Sad that don't want sex</p> <p>Sex difficult due to FGM</p> <p>Sex is different with FGM</p> <p>Sex is part of a relationship</p> <p>Sex key to a relationship</p> <p>Sex not relaxing</p> <p>Try and convince self that love sex</p> |
| | Relationship with mother | <p>Angry at mother</p> <p>As a mother responsible for making decision about children</p> <p>Ceased contact with mother</p> <p>Conflicting feelings about Mum</p> <p>Damage to mother daughter relationship</p> <p>FGM destroyed relationship with mother</p> <p>Hate mother</p> <p>Have to love and respect mother</p> <p>Ignorance of mother</p> <p>In my head I've killed her 100 times</p> <p>Left with no option but to forgive mother</p> <p>Let down by mother</p> <p>Love for mum was hidden</p> <p>Love mother because I have to</p> <p>Mother a coward</p> <p>Mother never apologised for FGM</p> <p>Mother not there when had FGM</p> <p>Mother proud I had been purified with FGM</p> <p>Mother should have protected her</p> <p>Mum didn't think of me, just herself</p> <p>Mum doesn't love me</p> <p>Mum felt guilty</p> |
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| | | <p>Mum had to leave the room when I had FGM</p> <p>Mum upset I had had it done</p> <p>No mother should ever hurt their child</p> <p>Relationship with mother got worse as got older</p> <p>So angry couldn't access love for mother</p> <p>Wanted mum to love me but she doesn't</p> <p>Why did mother hate me to do FGM</p> |
| Physical health impact | Pain | <p>Constant pain everyday now</p> <p>Pain</p> <p>Pain of FGM lasts whole life</p> |
| | Pregnancy / Childbirth | <p>Baby nearly died because of FGM</p> <p>Better to cut when giving birth</p> <p>Blame FGM for birth complications</p> <p>Complications giving birth</p> <p>Couldn't face having another child</p> |
| | Health complications | <p>Bladder inflammation due to FGM (adult)</p> <p>FGM health risks</p> <p>Infection due to FGM</p> <p>Infection in leg</p> <p>Ongoing physical health problems</p> <p>Urine infections</p> <p>Complications of FGM</p> <p>Complications with periods</p> <p>Complications with pregnancy</p> <p>Complications with sex</p> |
| Unmet needs | Lack of professionals' knowledge | <p>Ignorance of professionals</p> <p>Midwives have knowledge in Somalia not in UK</p> <p>Midwives not trained</p> <p>Need for more staff training in FGM</p> <p>Professionals not seen FGM before</p> <p>Professionals not trained in UK</p> <p>Need for workshops</p> |
| | Need for specialist services | <p>Clinic to be re-opened</p> <p>Need for specialist clinic</p> <p>Specialist pregnancy advice and services</p> |
| | Need for validation | <p>Impact of experience being validated</p> <p>Impact of feelings being validated</p> <p>Need for validation</p> |
| | Talking therapy | <p>Counselling helpful</p> <p>Getting in touch with psychological pain</p> <p>Got in touch with anger</p> <p>Need more support for survivors</p> <p>Need psychological support for survivors</p> <p>Talking therapy with husband</p> <p>Someone to listen</p> <p>Someone to phone and check ok</p> <p>Support from other survivors – group therapy</p> <p>Support survivors of FGM</p> <p>Survivors groups would be helpful</p> <p>Survivors need opportunity to talk</p> <p>Survivors need to get in touch with their feelings</p> |

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| | | <p>Survivors who recognise their journey</p> <p>Talk to get advice</p> <p>Talking helps people</p> <p>Talking is helpful</p> <p>Talking through feelings</p> <p>Talking to make sense of how feeling</p> <p>Talking to other survivors normalises feelings</p> <p>Therapy helps make sense of experience</p> <p>Therapy without stigma</p> <p>Talk to someone before get opened</p> <p>Trying to make sense of having had FGM</p> <p>Unconscious feelings</p> <p>Want to sit down and talk to someone</p> <p>Want to talk to someone who cares</p> <p>Want to understand - talking</p> |
| Resilience | Duty to share knowledge | <p>Share experience with other people</p> <p>Share FGM knowledge with others</p> <p>Shared experience with other survivors</p> <p>Should advise people</p> <p>Strive to help others</p> <p>Success of breaking cycle</p> <p>Survivors have a duty to help others</p> |
| | Luck | <p>Guilty about not having many complications</p> <p>Lucky</p> <p>Lucky to have had less severe type of FGM</p> <p>Lucky to have medical care after</p> <p>Lucky to not have pain</p> <p>Others are lucky not to have FGM</p> <p>Others lucky to have less severe FGM</p> <p>Unfair</p> <p>Unlucky</p> |
| | Empowerment | <p>Do not see self as a victim</p> <p>Don't want to feel sorry for self</p> <p>Feeling sad makes me stronger to help others</p> <p>I support other people</p> <p>Wouldn't want to help others if not for FGM</p> <p>Empowered</p> <p>Hide pain</p> <p>Taking control over FGM impacts</p> <p>Looking forward with life</p> |
| | Resisting continuation of FGM | <p>Don't want daughters cut</p> <p>Would never perform FGM due to own experience</p> <p>Marginalised if don't get daughter cut</p> <p>Advocate against FGM</p> <p>Campaigns against FGM</p> <p>Encourage family against FGM</p> <p>Seeing sister have FGM gave motivation against FGM</p> <p>Told husband wouldn't cut girls</p> <p>Want daughters to have better life than me</p> |

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| Stage of Life | Death of own mother | Had to forgive mother as she passed away Not real forgiveness, a forgiveness that comes with death |
| | Menstruation | Cannot pray during period Period as a reminder of FGM Periods causes psychological pain Periods lead to depressive place Hard when not able to pray (during period) |
| | Sexual relationship / marriage | Marriage Remember FGM at wedding Sexual relationship |
| | Childbirth and becoming a mother | Childbirth reminds of FGM Cleaning vagina after lost baby - reminded of having FGM Markers of being a woman in life – having children Impact of parenthood Promised would be a better Mum than her Mum Now have a child cannot even look at mother |
| Fear | Womanhood | Every month scared of period Fear FGM will open Fear for baby's life Fear going to die in childbirth Scared of pain of childbirth Scared to have intercourse Fear husband would leave Fear husband wouldn't be supportive Fear of going crazy Fear that husband will think I don't like him Scared of having intimate relationship Scared to have sex Scared to meet a man Fear husband would leave Fear husband wouldn't be supportive Fear of rejection |
| | Ability to cope | Fear of going crazy Fear cannot cope Fear makes me stronger |

Appendix M: Highlighted quotations from interviews carried out with women who had experienced FGM

| Conceptual coding | Axial coding | Verbatim Quotations |
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| Understanding of FGM | Lack of knowledge | <p>‘My mother passed away 2 years ago and to her dying day she apologised for a lot of mistakes that she made when raising us but she never apologised for doing FGM to me because she never saw anything wrong with it she thought I circumcise your younger brother and I circumcise you what's the difference’. (Faridah Lines 73-75)</p> <p>‘...if they educated, knew about the pain after that then they wouldn’t do it because they didn’t have any knowledge ... culturally if they were educated they might have said no don’t have it’. (Zahara Lines 274-176)</p> |
| | Religion | <p>‘In a weird way I blame religion, I know today we say nothing to do with it, but religion it never stopped it and people let it happen in the name of Allah. I love my religion, but it’s a disgrace that it was used as a reason’. (Ebony, Lines 82-84)</p> <p>‘... they are using religion as a scapegoat but in the Holy Koran it doesn’t say it at all, so this is culture, its nothing to do with Islam’. (P10, Fabia, Lines 225 - 226)</p> <p>‘...when I grew up and I learn and get educated and I make the research with the Muslim people and I see it ... there’s no way I can see where religion says about it’. (Sabina, Lines 267-269)</p> |
| | Role of men | <p>‘No-one is going to be married because a husband he maybe say you didn’t have FGM so you have no future, nothing, so that’s another pressure, we have to have it.’ (Jamina, Lines 143-144)</p> <p>‘...Back home I think the reason they were doing it is for the man’s sake, people were believing that without FGM the girl wouldn’t be a virgin and couldn’t get married as the man would reject her’. (Fabia, Lines 250-151)</p> |
| | Cultural pressure | <p>‘Yea its only cultural and they believe we have to have it because the things is we did we done for a long time so in their mind they say we have to have it ...why are we stopping ...because of our Grandma, or grandpa, we have culture’. (Jamina, 185-187)</p> |

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| | | <p>'I was young so that's why she didn't want me to have it ... but culture was pushing her to have it'. (Saleema, Lines 81)</p> <p>I'm angry because of the culture, they believe you have to have it, so I don't blame anyone but I do blame culture when I hear it, it makes me angry, why do they do these things to me'. (Zahara, Lines 261-263)</p> |
| | Female Identity | <p>'It's just the whole reality of just being a woman what I had to go through just for the fact I am a woman you know'. (Faridah, Lines 230-331)</p> <p>For me it seemed to be normal because all the ladies they have to go through this stage, they have to pass this stage [yeah] they have to go just through it because they are a woman. (Sabina, Lines 242-243)</p> <p>'...all the ladies they have to go through this stage, they have to pass this stage ... they have to go just get through it'. (Sabina, Lines 244-245)</p> |
| | Deception | <p>No, no permission forms or nothing, you go with your friends or with the neighbours, that's it. (Jamina, Lines 138)</p> <p>Dad was stronger than Mum, he knew I need FGM or wouldn't get married. He didn't need my Mum permission so he didn't it without her. (Ebony, Lines 88-89)</p> |
| Impact of Identity | Feeling different | <p>When I went to have the baby, they realise I have the FGM. I went to labour early and was very scared. When I got to the hospital the nurse ... er the midwife... she look at me and shouted for someone to come and look at me ... you know down below...Because she had never seen the FGM before and the baby was already trying to come out. The way she look at me ... it made me more scared and feel like such a freak ... er like I was different to normal people'. (Jamina, Lines 85-91)</p> |
| | Identity as a woman | <p>'I guess you could say I am not really a woman, I don't have all the parts that make me a woman'. (Halina, Lines 126-127)</p> <p>FGM took away my ability to be a woman my tearing, cutting and destroying me. I will never get over the loss</p> |

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| | | of my womanhood, silly really as I never really got to know it. (Samina, Lines 1598-1599) |
| | Loss of childhood identity | ‘...It took [my childhood] because the things I would do when I was young I wasn’t able to do it. When I see my kids they play or whatever they want to do. I feel I missed my childhood’. Saleema (Lines 156-157) |
| | Unknown Identity | <p>‘I know what happened changed me. I will never know if I was going to be the person I am or the child I was...she's taken that away from me. I will never know that, I will never know how its like not to have someone ... inserting fingers inside of you.’ (Vada Lines 407-410)</p> <p>‘Yes, o yes. I don’t know how FGM changed me but it did, I just will never get to find out how as I can never change it. Its gone, and so is how I was before it’. (Asha, Line 158)</p> |
| Emotional impact | Anger | <p>‘...I understand why people take a gun ... and shoot people, it's not an excuse but sometimes I feel so angry with the impact of FGM’. (Vada, Line 464)</p> <p>‘...FGM makes me angry because of the culture, they believe you have to have it ... it makes me angry’. (Zahara, Line 251)</p> <p>‘...In my head I've killed her 100 times’. (P12, Vada, Line 481)</p> <p>‘I hate her for what she did, I can’t have photo’s about of her as it makes me too angry’. (Saskia, Line 47).</p> <p>‘It makes me so angry that because I am a woman that I don’t get to enjoy the life that everyone else gets. I don’t get to enjoy sex and I don’t get a good life all because of being a lady. I feel so so angry and so upset and angry, I don’t even have the words for how angry I feel when I think about the FGM’. (Saskia, Lines 66-68)</p> |
| | Remembering FGM | ‘I think smell, there's certain smells that when I smell I think, o this smells familiar and it reminds me of the circumcision and er it's I think it's after the practice has been done and you know you have been cut out of sewing happens and your legs are sort of tied together and when you first go to pee its so painful that moment |

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| | | <p>and the smell i think there's certain smells [long pause] [that bring that back] yeah bring that back'. (Faridah, Lines 169-173)</p> <p>'Difficult yeah. I remember always. Especially when I have problems like with my health and doctors say it's because of FGM. You always remember it'. (Ebony, Lines 119-120)</p> <p>'They decide to cut me, and when she went to do it she didn't explain to me and I panic. I nearly kick her. Two of the nurses held me down. That was it...I was a little girl again being held down. Suddenly I could smell the blood and the room where I had the cut in the first place. I would see the lady who done it to me, only she didn't look kind she looked mad at me. Like she wanted to hurt me. It was like a bad dream and I couldn't wake up'. (Jamina, Lines 93-98)</p> <p>'...the reason why I have difficulties in childbirth is linked to the FGM ... so anytime I think about child birth FGM will pop into my mind'. (Samina, Line 1074)</p> <p>'...Most nights I hear her [sister] in my dreams screaming having her FGM'. (Fabia, Line 77)</p> <p>'...Every time someone grab me from behind, I jump and for a split second I think it the cutters again. Sometimes I turn the corner and I see them even though there is no one there'. (P16, Saskia, Line 88)</p> <p>'Eventually I can hear people were telling me that our younger sister .. you know was told she was dying. And you know what happened, has she had accident? ... We took her back to home but that/s the things I can never forget, I cannot remember much about FGM was painful or afterwards, but I cannot forget that day'. (Larissa, Lines 37-47)</p> |
| | Shame | <p>'No I didn't talk to anyone because I felt ashamed that I could not have the sex as other people would think I didn't love my husband'. (Jamina, Lines 70-71)</p> <p>'Sometimes it feel like embarrassing that people talking about your private parts in public place, often when people talk about FGM I feel like they are looking at me and I just want the ground to open. I feel so ashamed it has happened to me.' (Fabia, Line 303-304)</p> |

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| | Avoidance | <p>‘Sometimes I remember in the day but always I try to forget, I don’t want to remember’. (Ebony, Line 217)</p> <p>‘...I was so scared of childbirth I kept fainting and the doctor she got cross with me in the end and said I was doing it on purpose, but that wasn’t true. I don’t even remember the birth [were you given pain relief] no I was given nothing but I had to pretend it wasn’t me there as the pain was far far too bad as they had to cut me up again’. (Neema, Lines 52-56)</p> <p>‘...I dream that the lady who cut me and when I wake up I can physically still feel the pain. Technically there is no pain, but when I wake up from the dream, all I feel is the physical pain and yet I don’t feel sad’. (Keisha, Lines 105-106)</p> |
| Relational impact | Attachment with child | <p>‘I blame FGM!! If it wasn’t for that I would have had a normal childbirth and my daughter would love me, but they had to cut me and I think I resented my daughter for the pain I went through for a while’. (Neema, Lines 62-63)</p> |
| | Trust | <p>‘I have people I live with [mm] but friends? um ... um ... mmm...[laughs] that sounds so bad that I've never had friends ... this friend issue...I don't have ... I have trust issues’. (Vada, Lines, 100-101)</p> <p>‘I want to trust people yes, but I am scared to trust. I want to trust people yes, but I am scared to trust’. (Keisha, Lines 57-58)</p> |
| | Impact on marital relationship | <p>‘He might look around to have another to marry and to have another wife maybe, because you’re not ... you know you showing yeah you don’t care [mm] and it seems to him ‘she doesn’t like me, she doesn’t like me’ ... so you have to pretend.’ (Saleema, 266-167).</p> <p>‘I was too shy to ask him. The marriage was normal but to ask those kind of things I was too shy if I feel pain or if I feel no pain, I was shy to tell him. FGM create like a wall between us as even now I am scared to speak with him about it’. (Zahara Lines 166-167)</p> <p>‘Yes I try to avoid definitely. Normal women they relax and enjoy sex but for the woman with FGM, no I don’t enjoy sex. I try and avoid that part of my relationship,</p> |

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| | | <p>what's the point when I get no pleasure?' (Alia, Lines 202-203)</p> <p>'... sex is pointless; it gives me no pleasure and lots of pain'. (P17, Filomena, Lines 64-66)</p> |
| | Relationship with mother | <p>'She had to leave the room because it was too painful for her to watch me go through the practice that made me really angry really really angry that she went out of the room save herself but didn't think of me'. (Faridah, Lines 81-83)</p> <p>'FGM broke me and my mother's relationship for good, if you love your child you cannot hurt them, she was happy to hurt me' (Filomena, Lines 56-58),</p> <p>'...why did my mother not protect me from this, in fact on the contrary she's the one who put me through this' (Faridah, Line 220-221).</p> |
| Physical impact | Pain | <p>'Yes, you know the pain of FGM it never go. For the rest of your life you have pain like me'. (Sabina, Line 144)</p> <p>'...Personally, the physical consequences I had is having sex ... it's always hard because when you are closed ... after having sex you feel some pain and bruised'. (Samina, Line 470).</p> |
| | Pregnancy / Childbirth | <p>'I lost my baby completely at four months old [mm] ... It was 20 weeks pregnant and I had bleeding, starting bleeding [o gosh] and the baby comes out and then I had er ... [at 20 weeks?] at 20 weeks, because of the pressure of looking at the husband he wants to use it, you're closed ... you're going to give birth... how do they open for you? All those kind of things I was worried about'. (Saleema, Lines 218-222)</p> <p>'The problem come with that one because after I give birth they stitch it too much and when I come back home I had swollen my legs [o your legs were swollen], yea legs were swollen ... too much swollen, and I had infection ... um ... temperature, I can't walk, I can't even feed my baby [yeah] and after one year I had operation to open again [ok] yeah because difficult to do the urine and when I had um periods it was difficult [mm] ... feelings too much pain'. (Ebony, Lines 64-68)</p> |

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| | Health complications | <p>‘As soon as I start my period I feel pain [mm]. Even before I used to have infection all the time ... Yeah urine infections all the time. And then as soon as I started having periods still continues’. (Saleema, Lines 130-132)</p> <p>‘The problems I have until now because even now I have problem with the urine ... yeah I can’t do the urine when I’m on toilet ... I’m pushing but it’s not coming out, all the urea stays in my bladder and give me infection’. (Ebony, Lines 96-97)</p> |
| Unmet needs | Lack of professionals’ knowledge | <p>‘People see when they look at us as a victim because they don’t have knowledge of FGM, and that’s what are women are scared to look for a service that people see them as a victim [ok] or someone suffering. That’s not what they after, what they after is if they have particular communication then they should get the medical attention like you have diabetes, you have infection [yeah] and you go to your GP to prescribe you, to refer you, that’s what sort of things they want. They don’t want sympathy from anyone and you know to look at their different’. (Larissa Lines 560-563)</p> <p>‘The problem is the people here they don’t know FGM and need lessons to understand what it is and looks like’. (Alia, Lines 226-228)</p> <p>‘No, would never use health services here. Doctors in the UK don’t understand FGM, they cause more problems by not understanding’. (Asha, Lines 166-167)</p> |
| | Need for specialist services | <p>‘They need to have someone that talks to you before and while you have a baby. I would have wanted someone to help me and tell me what was going to happen but i never got that. That would be helpful. You know someone who was specially trained so you only see people who understand FGM.’ (Patience, Lines 86-89)</p> <p>‘...I think it’s good to be able to talk and make a clinic where we can have a group to talk about they feel and also somewhere they if we have been cut we can be opened before we get married.’ (Alia, Lines 225-226)</p> <p>‘...I think that they should have pregnancy support so that women who may have infection like me do not miss out on their child growing up, so they can continue to be a mum’. (Wilo, Lines 62-63)</p> |

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| | Need for validation | <p>‘It was just the way she dealt with the whole thing, she was deeply deeply caring and she was really deeply moved. She was just a doctor to examine me and then er I think it was just have sensitively with the whole thing [yeah] just stuck in my memory’. (Faridah, Lines 359-341)</p> <p>‘It was one of those moments where you think Ok I'm not going crazy I'm not the one who's thinking something horrible happened to me[yeah] look at this stranger you know, so it was just really good feeling I remember feeling really warm really really feeling you know’. (Faridah, Lines 367-368)</p> |
| | Talking therapy | <p>‘They need someone to advise them when they pregnant and talk through everything as it scary, very scary. Even now I think about my baby birth and get scared and if I had had someone to talk about it with they maybe would be easier. My friend she had a councillor and she say it was very helpful. The lady she helped her understand and comprehend. I think all lady to have the FGM after and before the baby should have councillor or some person like that’. (Amina, 139 – 143)</p> <p>‘...They need to have someone that talks to you before and while you have a baby. I would have wanted someone to help me and tell me what was going to happen but I never got that’. (Patience, Lines 86-87)</p> <p>‘It’s better to have a group because some women don’t talk about it so it’s better to have an organised group to talk about FGM so they would see more women talk and they would feel more happy to talk about how they feel’. (Zahara, Lines 335-337).</p> <p>‘...I think all ladies who have the FGM after and before the baby should have counsellor or some person like that to talk to’. (Amina Lines 142-143)</p> |
| Resilience | Duty to share knowledge | <p>‘That’s right. Although its feel you know sad, but still I have to stop because it’s happened to me I don’t want the other people to feel the way I’m feeling now, it’s my duty’. (Saleema, Lines 376-377)</p> <p>‘And its my responsibility to tell my daughters how bad FGM is and tell them everything I know about how bad it is’. (Halina, Lines 164-165)</p> |

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| | | <p>‘...I fight with everything I have against FGM ... I am not a campaigner or nothing, but if anyone says about FGM I warn them against it’. (Larissa, Lines 468-469).</p> |
| | Luck | <p>‘When I hear stories of you know because I am always active in the fgm campaign and attend a lot of talks and hear a lot of survivors stories and sometimes when I hear the amount of physical pain they have gone through ... thank God you know the least of my pain is the physical pain’. (Faridah, Lines 267-269)</p> <p>‘I was lucky because I didn’t feel pain when I had a period, I was normal when I started my period’. (Zahara, Line 101)</p> <p>‘To be honest with you I am lucky because some people have the hard one and its very very extreme whereas mine ... at least I am alive, some girls they die. Compared to some ladies I am lucky only being in a little bit of pain everyday, not a lot’. (Fabia, Line 216-218)</p> <p>‘...I was lucky; I didn’t have many health problems, and my baby was ok as I had the stomach cut [c-section] ... the only pain I have is period pain every month as it gives me lots of the urination infections’ (Keshia, Lines 34-36)</p> |
| | Empowerment | <p>‘I think the fact that I’m helping other women you know I think... I remember making a conscious decision that I need to do something about fgm and help other women [mm] and you know we say in Islam if you save the life of one person it’s like as if you have saved humanity. And in my mind I think what keeps me going is as an fgm campaigner, speaker out there and all that and thinking you know what I’m going to speak out about it and do something about it and if I can help one girl not to go through FGM [mm] then my life is worth it’. (Faridah, Lines 414-418)</p> <p>‘I’m the one in my family the new family I created to break that circle [mm] so for me it just ... rather than feel sorry for myself and seen as a victim I see myself as a winner in this battle, FGM battle’. (Larissa, Lines 457-458)</p> |
| | Resisting continuation of FGM | <p>‘...people they ask you why the girls they don’t have it, and I say and answer that I don’t want them to feel like I feel because my feeling was not good [mm] and my relationship not good because of FGM so I don’t want</p> |

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| | | <p>to do my girls the same [mm]. They have to feel more attractive and sexy you know ... my girls to feel comfortable'. (Amina, Lines 30-33)</p> <p>'I have an 18 year old and I never touch her... I wouldn't do it because its ... there is no explanation anywhere saying you have to do it and I don't want anyone to go through what I did'. (Fabia, Lines 107-109)</p> |
| Stage of Life | Death of own mother | <p>'She didn't protect me and she was the one person that should have you know protecting me and then she put me through this and how ignorant she was and this is my anger fuming. 'mm' but then one of those occasions where you have to get worse before you get better [mm] now to be honest (pause) I think because of the fact that she has passed away as well makes me think maybe I forgiven her'. (Faridah, Lines 91-95)</p> <p>'It's a forgiveness that comes with the fact that she has passed away. so I feel like as if I've been left with no option other than to because if I carry on the anger any more it's just going to damage me'. (Faridah, Lines 103-103)</p> |
| | Menstruation | <p>'Not the pain no, I think I go into a depressive place I think you know like when I feel the memories especially when I have my period and [long pause] because in Islam, I'm practising Muslim, I try to practice Islam, and pray 5 times a day and fast and you know things like that [mm] and er in the week that women have their periods are they are exempted from praying and fasting and all of those things, and because I'm not praying and I don't have that sort of spiritual awakening or consciousness I sink into a deep depression and then the smells and the connection with my femininity and all of that brings back memories of well I think it brings up memories that put me in a really down place'. (Faridah, Lines 175-181)</p> |
| | Sexual relationship / marriage | <p>'but I think it's a sexual abuse as well because something is done to that part of your body so anything that you know getting your period, when I first got married and have to have sex, you know penetration er [pause] just anything that happens to women [mm] is just difficult and painful'. (Faridah, Lines 188-191)</p> <p>'...like when you have sex the first time, when you have a child, first time having marriage ... and all kind big life</p> |

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| | | things you feel the pain and I wouldn't feel the pain if I didn't have it'. (Zahara Lines 306-308) |
| | Childbirth and becoming a mother | <p>'My baby nearly died and all because of the FGM. They cut me and tore me to get her out. It was the first time I felt really angry'. (Jamina, Lines 105-107)</p> <p>'As soon as I had my baby, I feel more to love my baby and I said no no no. 'This one not going to be happening to you'. (Lines 291, Saleema)</p> |
| Fear | Womanhood | <p>'Because I heard the other girls, the ones who marry and they explained to us what's going to happen so I was too scared to meet a man'. (Sabina, Line 163)</p> <p>'I was terrified of having my baby. I knew that women with circumcision have lot of problem when having a baby as it doesn't come out and they have to be cut, o I was very very scared. I thought they were going to butcher me again, like when I first had you know, the cut'. (Ebony, Lines 46-48)</p> <p>'I am frightened each month to get my period knowing it was going to be painful' (Sabina, Line 140)</p> <p>'I feel very sad a lot and cry alone a lot as I was scared he was going to leave. I had a lot of headaches as well because of feeling so scared'. (Jamina, Lines 67-68)</p> |
| | Ability to cope | 'When I think of FGM I feel frightened to be honest, but it's a good frightened as it reminds me of what I went through and makes me strong'. (Asha, Lines 161-162) |

Appendix N: Author guidelines for British Psychological Society Psychology of Women Section Review

Psychology of Women Section Review

The Psychology of Women Section Review provides a forum for discussion of all aspects of the psychology of women in research, teaching and professional practice. It aims to encourage the development of theory and practice concerning gender and other social inequalities.

Scheduled publication frequency:

Once a year

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Assistant Editor (Agora; Research Reviews): Jemma Tosh

Assistant Editor (Book Reviews): Helen Owton

Information for contributors

All papers and submissions for the Agora section will be peer-reviewed.

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All figures should be of reproducible standard. References should conform to the British Psychological Society's style, which is similar to the American Psychological Association (APA) system. The Society's Style Guide can be downloaded from www.bps.org.uk. (From the home page go to Publications/Policy and guidelines, and then General guidelines and policy documents. Select 'Society editorial style guide' from the list of documents.)

Papers should be between 3000 and 6000 words long, and submissions for the Agora between 200 and 2000 words. An abstract of up to 150 words should be provided with papers, however, no abstract is needed for Agora submissions.

Book reviews and reviews of research papers will normally be commissioned by the relevant Assistant Editors. Anyone interested in reviewing books or research papers should contact the Assistant Editor directly.

Authors should avoid the use of any sexist, racist, heterosexist or otherwise discriminatory language

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